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# PUBLIC HEALTH NURSING

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# Planning for 1934

## SUPERVISION

*This is the second in a series of editorials on this general subject of Planning for 1934.*

A supervisor of safety and training in one of our great public utilities wrote recently:*

> We have seen that active supervision is essential to efficient results. We know that it is a natural, reasonable process without which no industrial or commercial organization could hope to work. It is obvious that public health nursing can benefit by it as much as any enterprise. What does this mean to public health nursing organizations?
>
> In a business which is operated for profit alone, the owner has the right to adopt or reject any expedient which will increase efficiency. But the public health nursing association exists and works for the purpose of alleviating human suffering. There is always more to be done, and for every bit of inefficiency which is allowed to exist, some bit of human suffering continues unchecked. In view of this, has any association the right to neglect supervision, which is fundamental to good service?

Supervision has, of course, as its greatest aim, better service to the public. Frequently those responsible for the development of public health nursing services plan to save money by getting along without a supervisor, or by asking the supervisor to assume the responsibility for a district, thus curtailing her proper function and perhaps unwittingly curtailing the effectiveness of the whole staff. Nothing is clearer at the moment than the need of more careful organization of work, and no economy could be wiser than the maintenance of a full-time supervisor for every staff of six nurses or more. In smaller staffs, the executive director or superintendent usually assumes the duties of supervisor, while for the hundreds of one-nurse staffs, supervision and advisory services are offered by state supervising nurses, the American Red Cross, or insurance companies and, where all of these are lacking, the National Organization for Public Health Nursing does the best it can in a very general way to answer questions and give advice at long range. Everywhere, however, supervision is recognized as an efficiency measure.

Recently, the chairman of a nurses' committee asked "What does the supervisor really do? How does she save us money?"

Concretely, the supervisor plans the

*D. S. Weeks, *Fundamentals of Supervision,* PUBLIC HEALTH NURSING, October, 1933.

work of her staff in such a way that duplication in travel is avoided. She arranges the schedule so that one nurse does not carry a backbreaking load while another makes a few easy visits and calls in at midday for more work; so that the nurse who is prone to shirk gets her full share of work and the overconscientious nurse is protected from fatigue. She ascertains that each visit is made productive through talking over its purpose beforehand and its accomplishment afterward. She is there so that the staff nurse may have some one to consult who has wider experience and better judgment in baffling situations. She is there so that when complaints arise, there is some one in a position of authority to hear both sides of the story and make the necessary explanations. The supervisor sees to it that a concise and accurate recording of work gives a true picture of the service to its supporters. She offers to the nurses stimulation and incentive to better work through constructive individual criticism, through educational activities planned for the whole group—and again, so that the best nursing care and health instruction are given by the staff, resulting in the "satisfied customer" so essential to the growth of any enterprise.

In this particular field of work, there is another fundamental responsibility which can only rest with some one who is seeing the field as a whole, who knows intimately the type of case being carried day by day by a busy staff and who is in the strategic position of being able to direct and guide the efforts of such a group—that is, the vital necessity of *balancing the program*. By this is meant a current analysis, through daily acquaintance with the records, of the types of care being given by the staff as a whole and by individuals. Inevitably in a staff of five or six nurses there will be varying abilities and varying likes and dislikes. Here is a nurse who "loves babies," another "doesn't like chronics," another "never feels at ease with prenatals." Is each nurse learning to spread her emphasis evenly, develop her capacities fully; is she trying to place her effort where it is most needed in relation to the actual situation in her district? Here is a section of the city with a high communicable disease rate, another where the maternal mortality rate is high, and still another where, owing to a foreign-born population, the infant death rate is double that in the rest of the city. Who is to analyze such situations, direct the nurses' efforts and interests to them and be assured that their time is being productively used and that they in turn are using community resources to the fullest extent—who but the supervisor?

Finally, but by no means least, the supervisor is the greatest factor in maintaining the morale of the staff nurse, the congenial atmosphere in the office, the friendly, understanding attitude toward all the groups that go to make up "the Organization" and toward all those in the social and health field in the community. As Miss Gardner has so perfectly expressed it: "If a supervisor loves her own work and brings to it the highest ideals of service, there are ninety-nine chances out of a hundred that her nurses will work in a like spirit. If she is imbued with a feeling of loyalty to the organization she serves, the loyalty of her nurses may quite assuredly be counted upon. . . . Most important of all, if she has a feeling of intense personal interest for each individual patient and a sincere sympathy for his situation, her influence will be carried into every home visited by her nurses."

Taking all these points into consideration and realizing that the Civil Works program is calling for the development of supervisory functions among small staffs as well as large, the N.O.P.H.N. Committee on Adjustments wishes to reemphasize the importance of such supervisory service and to point out again the essential economy of such service at the present time.

*Nurses in the Civil Works Service will find special reference reading on page 98 of this magazine.*

## CIVIL WORKS PROJECTS

Good news of importance to all in the public health field comes from Washington:

The U. S. Public Health Service, in coöperation with the newly created Civil Works Administration and the health departments of twenty-four states, has undertaken two Civil Works projects that will be of particular interest to all those interested in the improvement of health conditions. One of these projects provides for the employment of 29,000 men on drainage work in fourteen states for the elimination of breeding places of the malaria-carrying mosquito. The other employs approximately the same number of men on the construction of outside sanitary toilets in small towns where the extension of sewers is not practicable and where the danger of spread of excreta-borne diseases, such as typhoid fever and infantile diarrhea, is greatest. No government funds will be used for materials. Local agencies can render valuable assistance on the projects in their towns by helping to develop public interest and by persuading individual families or local governing authorities to furnish the materials required for the construction of the sanitary toilets.

It is understood that State Civil Works Administrators have made available to the state health departments in several of the states a large number of unemployed nurses to be assigned to generalized public health nursing service and visiting nursing service for the needy. The Public Health Service is assisting the state health officers in organizing this additional temporary nursing service by detailing Doctor Estella Warner and Miss Pearl McIver, Public Health Nurse, to the field for this purpose. The public health nursing work will cover the usual activities within the scope of a generalized nursing program, including communicable disease case work, immunization, school health work, prenatal and infant care, and bedside nursing service such as is generally furnished by a visiting nurse organization. Doctor Warner and Miss McIver are already in the field.

## CHILD HEALTH RECOVERY

The Children's Bureau reports that the Child Health Recovery Program initiated at a conference in Washington in October by the Secretary of Labor, is getting under way in a large number of states. The conference was called because of the evidence of an increase in malnutrition among children as a result of the depression, and proposed as an objective the location of undernourished children among families on relief and among those in need, though not on relief. It was also proposed at the conference that further plans be developed to overcome as far as possible existing malnutrition and to prevent its further progress through dietary means, and, where necessary, the institution of corrective medical procedures. In most of the states, the health departments are developing plans of procedure to locate and help malnourished children in cooperation with the Relief Administration, medical societies, nursing and nutrition groups, parent-teacher organizations, and others.

Recently further impetus has been given the program through the endorsement by the Federal Relief Administrator of Civil Works Service Projects in the states, by which needy nurses are to be employed under the supervision of qualified public health nurses to do child health work, with special reference to nutrition. Many such projects are already under way.

For use in connection with the program the Children's Bureau has published a child health examination form for physicians which emphasizes the nutrition picture of the child, instructions and height-weight tables for children under 16 years, and a one-page flyer covering the needs of the undernourished child. This latter should be especially useful to public health nurses. All of these publications are available on request to the Children's Bureau.

# The Rôle of the Public Health Nurse in Communicable Disease Control*

By GAYLORD W. ANDERSON, M.D.

DR. CHARLES V. CHAPIN, who recently retired from the position of health officer of the city of Providence after forty years of distinguished service, has been quoted as saying that the use of the public health nurse in the application of communicable disease control measures has constituted one of the outstanding recent advances in this field. Such a judgment from any other than Dr. Chapin might well evoke surprise and even challenge in view of the tremendous progress recently made in methods of disease control through immunization. Certainly it is a bold statement to rank the work of the nurse in as high a class in the scale of values. Yet a judgment from a man of such experience, a man whose appreciation of values has kept pace with scientific developments, who has seen and even assisted in the discard of many of the teachings of his youth, and their replacement with sounder conceptions, merits the most careful attention.

### A POLICEMAN AND PROVIDENCE

The full significance of Dr. Chapin's statement comes more clearly in view if we pause to contrast the communicable disease control measures of forty years ago with those of the present day (which I hope and pray will forty years from now seem to be just as outdated as are now those of 1893). In those days a burly policeman and a kind Providence were supposed to be co-partners in this field. The former's share of the work was to obtain the strictest observance of the letter of the law pertaining to isolation, quarantine, and above all terminal fumigation. To Providence was assigned the task of warding off epidemics, and carrying the patient through illnesses for which medical science had not as yet found a specific treatment. The health officer and physician followed along certain well trodden paths, carrying out procedures whose chief merit was the respect normally pertaining to age. We should not, however, be critical of the measures of those days for they were the best available, consistent with the knowledge then current. They were applied with a fervor and a sincerity which many of us today might well copy. Yet sober judgment must tell us that most of these measures accomplished little if anything in the field of disease prevention. Communicable disease continued unabated, each year exacting a horrible toll of life. Epidemics were not prevented nor is it probable that they were cut short. Like the famous King Canute, we stood on the beach attempting to sweep back the tide with naught but a broom.

### GERMS DO NOT READ PLACARDS

For the year 1933, we may paint a somewhat brighter picture. The methods are vastly different. Isolation and quarantine are coming to be regarded in their true light as adjuncts to control measures and not as the main reliance against an invisible and evasive foe that cannot read the gaudily colored placards. Terminal fumigation (except following insect borne diseases) has been discarded in favor of the far more useful and less objectionable concurrent disinfection. The present-day health officer actively combats diphtheria through immunization of the susceptible portion of the population, rather than passively waiting for cases to occur and be locked up. Explorations are being made into the still confusing realms of immunization against other diseases. The public health laboratory assists the physician and health officer in bacterio-

*Presented at the Meeting of the Massachusetts Organization for Public Health Nursing. Boston, November 3, 1933.

logical diagnosis of cases and carriers. A benevolent government furnishes serums for treatment and vaccines and toxins for immunization. Finally, making her presence felt in all the phases of the disease prevention problem, we see the public health nurse, quietly and without ostentation or glamour carrying into the home itself the present-day knowledge of disease prevention. It is certainly a far different era in communicable disease prevention, for its entire keynote is one of sympathetic help as contrasted with one that too often held an element of cold and heartless ostracism.

The rôle that the public health nurse occupies in this field is probably better understood if we attempt to analyze the various methods at present employed. Most obviously the first measure of control is directed toward the prevention of the transfer of the infectious agent from one person to another. It is impossible to prevent the infected case or a carrier from giving off these disease germs for they escape from the body through the vehicle of vital secretions or excretions. Control measures are therefore designed so to regulate the individual or so to influence the environment that these germs will not reach a new host.

#### CAN THE COMMUNITY BE PROTECTED?

The former of these, the regulation of the individual through isolation and quarantine, is far the less effective of the two. It is administratively cumbersome and through its unpopularity encourages evasion. I suppose it is almost heresy to question the value of isolation and quarantine as measures for disease prevention, yet it is a fact that we must face, whether we like it or not, that these measures probably contribute but little to the community protection. I use the words "community protection" advisedly for it is the protection of the entire population that I am considering for the moment. I fully recognize the fact that isolation and quarantine may here and there protect an individual child from a given source of infection. This probably occurs sufficiently frequently to justify our continued observance of these precautions. The fact remains, however, that when we consider the entire community, such forced segregation of the known infected and susceptible contacts contributes but little to the arresting or lessening of an epidemic, except perhaps under very rural conditions. The reasons for this are obvious when we remember that these procedures depend for their effectiveness on the recognition and segregation of all the sources of infection as soon as they develop. If each person were to infect ten others, recognition of as high as 90 per cent of the infected would not prevent a constant and regular spread of the disease. That prompt recognition of all sources of infection is impossible is apparent when we consider the frequency of carriers, of missed cases so mild as to defy diagnosis, of hidden cases, and furthermore remember that some of these diseases are in their most infectious stage in the period immediately preceding the development of those signs and symptoms which make diagnosis possible. Obviously, therefore, it is Utopian to believe that we will ever attain the time when we will be able to recognize all sources of infection as soon as they develop. In isolated instances where a small group is to be dealt with, it may be done, but on a community scale it involves advances in medical science which still seem far distant and most of all involves a degree of community education which seems even more remote of attainment. Some have claimed to have recognized all cases, but serious analysis of the data usually convinces the somewhat skeptical epidemiologist of the fallacy of such claims.

#### INDIVIDUAL PROTECTION GREATER APPEAL

It is, therefore, in the field of individual rather than community protection that we must seek the principal accomplishments of isolation and quarantine procedure, and it is here that the intelligent and sympathetic public health nurse can often accomplish far more than can the frequently brusque and at times even officious quarantine

officer. The mother who appreciates the reason underlying isolation precautions, who realizes that these are as much for the protection of the sick as of the well, is far more ready to coöperate than is the one who is brusquely told what she may or may not do. I personally doubt if the health officer, be he ever so tactful, or even the attending physician can gain the confidence of the housewife to the same extent as can a sympathetic and thoughtful public health nurse.

Measles and whooping cough are diseases in the control of which isolation and quarantine are notoriously ineffective. In both instances the major portion of the spread has been accomplished before the disease has developed to the stage which prompts the parent to summon the physician. It is but natural, therefore, that health officers should have despaired of attempts to prevent the spread of the disease and concentrated their efforts on attempts to prevent deaths through complicating pneumonia. Of this we shall have more to say later. At the moment it suffices to point out that one large American city has discarded isolation and quarantine in the control of measles, substituting a voluntary and recommended isolation of the patient, not for the benefit of the public, but for the protection of the patient against a possible infection with organisms which might lead to pneumonia. This is, therefore, an isolation of benefit essentially to the patient, and as such has a far greater appeal to the householder and is, therefore, far more likely to be observed. Suffice it to say that in this community the measles mortality, rather than increasing through such a procedure, has actually declined to a surprisingly low figure.

#### OPPORTUNITY OF HEALTH EDUCATION

No discussion of the nurse in relation to isolation and quarantine would be complete were we to forget the very obvious contact that this establishes with the householder. The far sighted health officer will, in every way possible, utilize his nurses in the routine quarantine measures, not solely because of the better understanding of rules and regulations that will result, but in the interests of the entire public health program. Generalized nursing is today rapidly replacing the separation of nursing duties. Through a quarantine call the resourceful public health nurse is able to present other matters pertaining to public health at a time when a worried mother is in a particularly receptive mood. It is human nature to be optimistic and to procrastinate when all is well, and it is likewise but human nature in the face of adversity to consider carefully such measures as might avert a repetition of the same or a similar misfortune. What nurse visiting any case of communicable disease can be said to have made full use of her opportunities if she has failed to point out that while the case in question might not have been prevented, there are at least two diseases, diphtheria and smallpox, which can be avoided through proper immunizing procedures? The importance of protecting the small child against measles and whooping cough should not be overlooked at this time. I feel confident that if these simple bits of information and advice could be brought to the householder whenever a case of communicable disease was reported, we would be making far greater strides toward our goal of disease control than we have ever accomplished through the strict enforcement of isolation and quarantine.

So much for isolation and quarantine. They are measures essentially of personal benefit and as such are probably worthy of retention. As community control measures, they are certainly disappointing, and especially so unless viewed in their proper perspective. They do, however, afford to the energetic public health nurse an opportunity for contact that may be of the most far reaching value in general community education.

#### REGULATIONS OF THE ENVIRONMENT

The second method of prevention of the transfer of disease-producing germs from one person to another is through

such regulation of the environment as will result in their destruction outside of the human body. This method, which is so strikingly effective in those diseases to which it is applicable is, however, largely beyond the scope of the medical or nursing profession. It is the special pride of that specialist in environmental control, the sanitary engineer. The construction and maintenance of water supply and sewage disposal systems are the keystones in the fight against typhoid fever; the drainage of mosquito breeding areas, the destruction of the larvae, and the proper screening of dwellings are our sole reliances in malaria control; the pasteurization of milk is our principal protection against milk-borne infections. Yet small as may be the part that the public health nurse plays in the application of these methods, she may play a very vital rôle in the creation of popular sentiment which will demand and support such disease control measures. We are all aware of the fact that in many instances the community nurse is looked up to as an unbiased adviser in health matters. She has won the confidence of the people through the service that she has rendered to them in time of sickness. Few persons are able to mould public opinion on matters pertaining to community health to the same extent as can the nurse. Thus though her rôle is not dramatic and is acted for the most part unnoticed, she can very easily be a deciding factor in the education of the community to the appreciation of the value and need of these essential environmental control measures.

The methods of communicable disease control in the application of which we have so far considered the rôle of the public health nurse are those designed primarily to prevent or at least limit the dissemination of the infection throughout the community. As this is our ultimate goal, these methods may be described as the most logical and the most desirable measures at our command. That they are not completely successful is self-evident from the fact that the diseases continue to occur. The reasons for these limitations we have already discussed. Let us, therefore, with but a final word of regret that what in theory is so simple is so complex and difficult in practice, pass on to another type of disease control, namely, the increasing of the resistance of the new host.

### RESISTANCE OF THE HOST

Every infectious process is made up of two parts, the infecting organism and the host. Just as blindfolded justice weighs the opposing evidence in her scales, so does nature balance the resistance of the host against the power of the invading organism. No matter how little or how great the resistance of the host, diphtheria does not develop in the absence of diphtheria bacilli. This is today a truism, well established after years of bitter controversy. Conversely, the presence of diphtheria germs in the nose or throat of a child does not necessarily mean that that child is ill with the disease that we call diphtheria. For every infectious process there are two opposing forces, the relation of which to each other determines the clinical result. This is not the place to discuss the factors conditioning the infectious power of a microörganism, nor need we concern ourselves with the physiology of the mechanism that we call resistance. We only need to remember that resistance is a very definite phenomenon which is always of paramount importance in the protection of the individual against the ill results of communicable disease.

Granted then, that this mechanism of resistance exists, it is but logical that efforts should be made to make use of it in disease prevention. Whenever the clinical process that we call disease occurs, it means that the germs that have escaped from our control have found residence in a host lacking sufficient resistance to ward them off without a struggle. Since we have not been able to prevent the spread of these germs, can we not attack the problem from the other side and so elevate the level of the resistance that the seeds may fall on barren ground? This is exactly what is attempted through the use of immunizing procedures.

### SELF-PROTECTION AND SELF-PRESERVATION

Were an impartial observer from another planet and entirely devoid of the imprint of the little prejudices of which we are all the victims, to visit this earth and be presented with the possibilities of disease control through this method of immunization, he would probably form the conclusion that this was an ideal method which would be accorded unanimous recognition, inasmuch as the individual resistance so established would be an asset in the gratification of the overpowering urge of self-preservation. It is essentially a selfish method in that the principal benefit is realized by the individual who obtains for himself this protection. The extent of community protection through the lessened incidence of the disease is somewhat problematical owing to the still present menace of a carrier condition. It is, therefore, logical to suppose that this method would be one of the greatest human appeal. That it is, is attested by the millions of persons who have been protected against one disease or another in this way. The control of smallpox in well vaccinated communities, the virtual eradication of typhoid in the military units through universal inoculation, and the more recent striking decline of diphtheria through the use of toxin-antitoxin and toxoid are remarkable instances of the cordial acceptance accorded the development of these disease-prevention measures.

### NOT UNIVERSALLY RECOGNIZED

In spite of these tremendous accomplishments we are daily faced with the fact that these measures, so effective, so logical, and apparently so appealing in their nature are by no means accorded the universal recognition that they so eminently deserve. During the past twelve months in Massachusetts, diphtheria has sickened over 1,100 children of whom about 100 have died. Great as may be our satisfaction over the thought that this is not only a marked reduction from the toll of previous years but is actually the lowest ever recorded in Massachusetts, we are still faced with the unpleasant thought that all of these cases might have been prevented, all of these lives might have been spared had we convinced the parents of these particular victims that diphtheria immunization was of real benefit to the child. These cases mean simply that in these instances the contact that should have been made was either not established or was unsuccessful.

Such a failure would be bad enough if it were measured only in terms of those who have actually been missed and subsequently contracted the disease. We know, however, that for every child unimmunized who contracts diphtheria there must be several others equally susceptible who may later be sickened. Even worse is the thought that as new children are added to our population through birth we are not succeeding in the goal of making every mother realize that this protection is of value to the new arrival. Discouraging indeed is the thought that here are the victims of tomorrow, and yet in spite of our endeavors we are not completely successful in averting the tragedy that will eventually cloud so many homes.

### HOW ACCOUNT FOR FAILURES

Such being our failures it is well to pause for a moment to consider wherein we have failed, for only through such an analysis can we map our future course. The Metropolitan Life Insurance Company* has recently analyzed the reasons why some two thousand children in our far western states had not been immunized. The reasons given by the parents were, of course, varied but could be classified into five different groups. Of the entire number, fifty percent had been left unimmunized due to *lethargy*. The parents had put it off until a more convenient time, had not bothered to arrange for it. These children were left unprotected simply because of the inertia of the parents. Had the matter been called to their attention in a manner which would have forced them into action, there is no question as to the ultimate

*Shepard, W. P., *Am. J. Public Health*, XXIII, 547, 1933 (June).

immunization of these children. Nothing more than a home visit from a public health nurse, at which time the parent might be given an opportunity to sign a consent slip would have reduced the non-immunized group by fifty per cent.

The second largest group (21% of the total) was comprised of those whose parents had delayed because of *ignorance*. This does not mean that the parent was essentially ignorant. In some instances the parents had never heard of diphtheria immunization, others thought it was unnecessary so long as the community was free of the disease, and still others had thought it could be safely postponed until the child entered school. All of these were cases of misunderstanding which might have been remedied had there been an opportunity for a personal interview. As with the previous group these children would probably have been protected had the public health nurse made a home visit for this purpose, or even discussed the matter at the time of some other visit.

A third group which might have been reached through public health measures included those whose delay had been due to *economic difficulties*. In these instances the child would have been protected had the family been able to afford the physician's services or had there been a free clinic. This group accounted for almost seven percent of the total. In Massachusetts such a group would be inconsequential as there are only some 25 communities (most of them very small) in which the local health authorities have been so negligent, so unappreciative of their responsibilities, as to fail to provide the opportunities for free immunization. I blush to acknowledge that there are any such health officers today, but I suppose it will always be human nature for some adults still to believe in Santa Claus.

Legitimate *medical reasons* for failure to be immunized comprised a fourth but small group of less than one percent of the total. What these may have been other than a former negative Schick test is hard to imagine. We must, however, accept them. In the consideration of the whole problem of why parents fail to have their children immunized against diphtheria, they occur so rarely that they can be ignored.

Those parents actually *opposed to diphtheria immunization* comprised 22% of the total. I suspect that this figure is somewhat larger than would be encountered in Massachusetts owing to the well known prevalence of cultism in some sections of the far West. Unquestionably many of these persons might be convinced of the error in their judgment were the proper approach made to them. In many instances the opinion is based on misunderstanding or misinformation. We are all aware of the radical changes that occur in stories as they pass from person to person. Hearsay and gossip are poor foundations on which to rest an opinion which may influence a child's protection against disease. Yet who of us cannot recall the mother who was opposed to diphtheria immunization because she once heard of a child who was said to have been made sick from it. Careful inquiry as to the identity of the child or the extent of the injury reveals usually an extreme vagueness as to details. Such a parent has frequently formed a hasty judgment on the basis of mere hearsay and can be readily convinced if someone will but discuss the matter with her so as to clear up the misunderstandings.

### HOW PREVENT THE FAILURES

Reviewing these figures, it is apparent that at least eighty percent of the immunized children in this study might have been protected had the proper steps been taken to bring this about. Some will say that the family physician was to blame in that he had not immunized the children for whom he was caring. Unquestionably the family physician could do more preventive medical practice than is the case at present. Each year probably sees an improvement. In the field of diphtheria immunization the modern pediatrician is playing a rôle of ever increasing im-

portance through the incorporation of this procedure as a routine in the care of the first year of life. There is still, however, an unfortunate belief in certain elements of the medical profession that to urge the parents to bring a child to the doctor for immunization, which in turn means a fee for the physician, is akin to advertising and therefore unethical. However much we may disagree with this point of view, we must respect it, and give due consideration to it in the formulation of a program to reach this large group of non-immunized children.

Another mode of approach is through the health officer. Unquestionably better methods of publicity might be devised. A well planned educational program is of vital importance in the conduct of every diphtheria immunization campaign. Yet such methods lack the personal appeal which is so vital in this work. So exaggerated are the claims of most of the commercial advertisers that the public naturally discounts most of the so-called propaganda, and in doing so applies the same discount formula to the literature of the health department that it does to that of the cigarette, automobile, "health food" or cough medicine.

#### THE KEY PERSON—THE PUBLIC HEALTH NURSE

It is to the public health nurse that we must, therefore, look for the answer to the problem of reaching the parents of the unimmunized child. We have seen that some eighty percent of these could be convinced were the proper approach made to them. If 50% of it be due to inertia or lethargy, it is obvious that the initiative must be taken by the health agency for we cannot expect these parents to take the trouble to read what has been prepared for them. If over 20% be due to misunderstanding, the initiative must again be taken by the health agency for the person who misunderstands will certainly not make an effort to find the error which he does not realize exists. Just as the proverbial horse does not always drink when led to water, so the mere exposure of the public to information does not always lead to absorption of knowledge. To correct those misunderstandings a personal visit is probably necessary. There is no one in the entire field of health workers who can compare with the public health nurse in this work. She has the entrée to the home. She has frequently rendered a service which has won for her the respect and regard of the people of the community. It is certainly no exaggeration to say that there is hardly a person in the large group of public servants or in the army of health workers who is so highly respected in the community as is the public health nurse.

This consideration of the possible influence that the public health nurse can exert upon the general acceptance of diphtheria immunization is not based solely on theoretical considerations. It has been so well substantiated in the field of experience that it is today hardly open to dispute. It is common experience to see neighboring and comparable communities which differ widely in their immunization status. I have in mind a community of some 5,000 population in which less than 500 children have been immunized in the past ten years. The board of health's inertia has been largely compensated for by the interest on the part of the superintendent of schools, yet the local nurse has shown as little interest in immunization as though it were a phenomenon peculiar to the most distant planet of the solar system. In three towns less than ten miles distant and served by equally inactive boards of health but blessed with the services of an active and resourceful nurse, over 90% of all the school children have been immunized, and the number of children protected before even reaching school age is proportionately high. The difference lies solely in the public health nurse. The one is satisfied so long as she holds her job, and sees nothing in her work other than a few routine tasks to be performed. The other has a vision of the important rôle that the public health nurse may play in the practical application of this second type of disease

control measure, the raising of the resistance of the individual to such a high level that the germs whose spread we have not prevented may not successfully attack the new host.

### WHEN NO IMMUNIZING AGENT EXISTS

So far we have considered communicable disease control through limitation of the spread of the infecting organisms and through increasing the resistance of the new host. We have had a glimpse at the important part that the public health nurse may play in this work. It is obvious, however, that in many instances neither of these methods may be effective. We have already seen how futile are quarantine procedures in the control of measles or whooping cough. In the case of neither disease have we as yet effective measures for universally raising the level of resistance. In combating infantile paralysis we must confess ourselves to be even more helpless. Failing in these two attempts we must, therefore, exert our utmost efforts to minimize the ill effects of the attacks which we have been so unsuccessful in preventing. An epidemic wave of any of these diseases may well constitute an emergency from the public health point of view. Godfrey has well stated the situation when he said that in a single measles epidemic more lives may be lost than have been saved through an entire year of well-baby conferences. Although this statement has been challenged as too sweeping, we must all acknowledge the element of truth contained therein, that too often the official health agency regards measles as little more than an act of God, and sits back complacently to keep the score. Such an attitude is certainly the very essence of futility.

### MEASLES AND WHOOPING COUGH

The problem of measles (as well as whooping cough) is essentially one of protection of the younger age groups. Eighty percent of the deaths from measles and ninety percent of those from whooping cough occur in the first three years of life. These deaths are, in most instances, due to a complicating broncho-pneumonia. The problem that presents itself is to educate the parents of the children of this age group to the fact that measles and whooping cough while comparatively mild in older children may be among the most serious of all diseases that the younger child may have. So universal are the two diseases and so few are the deaths as compared to the cases that the public too often considers these as minor diseases of childhood. They fail to remember that they are two of the commonest causes of death. This popular lack of concern and respect is often manifested by the self-medication that is used. The diagnosis is made by the parents, or through comparing notes with a neighbor over the telephone or back fence. Medical and nursing care are of the same order, and are successful in most instances, especially with older children for whom the infections are so relatively harmless. When, however, two weeks later the baby develops sniffles and later a rash, the same household measures are not so effective and disaster often follows. The public fails to realize that to all intents and purposes measles or whooping cough in a baby is a very different disease from that seen in an older child. In reducing the toll from these diseases the health department may well devote its energies to the problem of intensive education of these households where these small children are to be found.

In the carrying on of this educational work no agency is so effective as is the public health nurse. So firm is my conviction in this regard that I am willing to express the opinion that the public health nurse can do more in the reduction of the present high mortality rates from measles and whooping cough than can the health officer or the medical profession. In making this statement I am not discounting the stimulus to the program that may come from a broad visioned health administrator. Nor am I unmindful of the fact that the physician may through the use of convalescent serum if available, or through parental whole blood, so modify measles in the smaller children as to eliminate most fatalities. It is self-evident, how-

ever, that the physician has no such opportunity unless he is called promptly to see the first case in a family, and that he will not be called unless the family is appreciative of the real importance of measles. So long as the public thinks of it as a minor disease, the occurrence of which often provokes smiles, the family physician is given no opportunity to care for the case at a time when real assistance can be rendered. Particularly is this true in the lower economic levels where most of the measles deaths occur, and where for financial reasons there is a strong tendency to avoid calling the doctor whenever possible. It is thus through popular education concentrated upon the parents of a certain age group that the public health nurse can contribute to the reduction in the death rate from measles, and similarly though less strikingly to whooping cough. It is in this manner that I feel the nurse is able to make a greater contribution than can any other agency.

#### THE NURSING VISIT TO A COMMUNICABLE DISEASE CASE

So far nothing definite has been said as to the content of the nursing visit to a case of communicable disease. The time is too short to do justice to such a subject, nor could I hope to improve on the general principles laid down by the National Organization for Public Health Nursing.* I should, however, like to impose upon your patience a few minutes longer to give some consideration to what I consider to be a serious misconception as to the rôle of the public health nurse in communicable disease control. This misunderstanding arises, I believe, through a failure to consider carefully what is to be accomplished by a nursing visit. Valuable as may be a social visit to establish a working contact with a family, there should be in the nurse's mind a clear picture of the goal to be attained by every nursing visit. Each visit should have a definite purpose, dependent upon the disease in question. Yet it would appear that many of the standards drawn up by some agencies as to frequency of visits have been arrived at without much thought being given as to the content or purpose of each visit which is made. In fact it would seem as though the frequency of the visits had been conditioned more by the medical severity of the case than by consideration of the potential accomplishments of such visits. Such is, of course, desirable so far as concerns the ministrations of the attending physician, but is it sound to set the same standards for public health nursing? For example, one standard prescribes four nursing visits to a case of cerebro-spinal meningitis and but two to a case of measles. At the risk of being considered cynical, I must say that I can see little to be accomplished through more than one or perhaps two visits to the meningitis household. Our only control measures today rest on isolation and quarantine, and as actual supports they strongly resemble the rubber cane of the movie comedian. Yet in measles we have a disease in which three or four visits properly spaced might be extremely effective in lessening the mortality. For example, a first visit at which time a census of smaller children might be obtained, so as to urge special protection of these; a second about 10 days after the onset and therefore a couple of days before the onset of secondary cases in younger brothers or sisters, the purpose of this visit being to impress upon the mother the importance of proper care for this prospective victim; and third, a visit a day or so after the probable onset of the secondary cases, this visit being to give emphasis to the need of adequate medical care if such has not been provided. A fourth and farewell visit would, of course, be needed if placarding were used.

These may seem to be extreme examples, yet in practice they are almost an understatement of facts. Rather than the two prescribed measles visits from which so much may be expected, it is too frequently found that none are made, whereas the meningitis household where so little may be done is accorded

*See N.O.P.H.N. Manual of Public Health Nursing.

a daily visitation. I sincerely hope that when these standards are revised those responsible for them will consider more carefully the rôle of the nurse in respect to each of these diseases rather than merely the clinical severity of the case.

#### HITTING THE VULNERABLE SPOT

Herein lies the key to a successfully planned program for communicable disease control. We have long since passed beyond the stage of blind and empirical dogmas in this phase of public health. The modern health officer adapts his control measures to fit the epidemiological characteristics of each disease. Although in most instances more than one type of control measure is applied, the principal stress is laid on that which strikes the disease at its most vulnerable spot. Just as the manner of attack varies with the peculiarities of the several diseases, so will the rôle of the public health nurse be dependent upon those special characteristics of the diseases which lend themselves to the nursing approach. The successful health officer is he who has sufficient vision to utilize successfully the nurse in that phase of the work for which she is so admirably adapted, and the successful nurse is she who shows the resourcefulness, the initiative and the imagination to capitalize for the public benefit the many excellent opportunities offered to her in the field of communicable disease control.

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## WHAT—NO IMAGINATION?

To date (January 5) not one entry has been received for the improvised equipment contest being conducted by this magazine. The judges are beginning to think they will not have to work at all! Two of the judges have been appointed—the third we are waiting to hear from. Mary Emma Smith, Director of Nursing Activities, National Society for the Prevention of Blindness, and Dorothy J. Carter, Assistant Director of the N.O.P.H.N., have consented to serve as judges.

We repeat the rules of the Contest:

The magazine is offering prizes of $25.00, $20.00 and $15.00 for a description or model of the best piece of improvised equipment made from materials obtainable in or by the average home, for use in home nursing care, demonstrations, *health education* in home, school, industry, or clinic. The description of the equipment must not have been published elsewhere, the materials used must represent less cash expenditure than if the article were purchased complete at a store, the article must have been tested and proved to work in actual use and must be the original idea of the individual or staff submitting it. This contest is open to all graduate and *student* nurses. The equipment may be submitted as a sketch or photograph and description, or model and description. Models will not be returned unless return charges accompany entry.

Decisions will be based on

(1) Practical ingenuity displayed
(2) Effectiveness as a means of health education
(3) Inexpensiveness.

We are particularly eager to see *health education* materials included in this contest.

The winning equipment will be on display at the N.O.P.H.N. booth at the Biennial Convention in Washington, D. C., in April as well as being announced and described in the May number of this magazine.

This contest closes midnight, February 20, 1934. Entries should be sent to Contest Editor, PUBLIC HEALTH NURSING, 450 Seventh Avenue, New York, N. Y., and must be labelled clearly with the pen name of the contestant (or contestants), the real name accompanying the entry in a sealed envelope.

# The Tuberculosis Picture of 1933*

By EDITH M. BAKER

EVER since medical social work was inaugurated almost thirty years ago, emphasis has been placed on case work with tuberculous patients. In the past, however, medical social workers have demonstrated their skill in accomplishing such tangible results as improvement of unfavorable environmental conditions and the meeting of financial problems better than they have the more subtle influencing of mental attitudes and the development of character under adversity on the part of the sick person. It is only during recent years that they have become more conscious of and articulate concerning this phase of case work.

### FACING THE DIAGNOSIS

A knowledge of the patient's emotional attitude toward the disease is important. The fact that the individual afflicted with pulmonary tuberculosis shows profound changes in his character and mental traits as a direct result of the disease has frequently been commented on in literature, but medical opinion seems to agree that although no direct effect of the disease on the function of the nervous system is evident, certain mental states are apt to be found. These are probably due to the many new adjustments the individual is forced to make. It is quite evident that the sudden realization by an individual that he is suffering from a possibly fatal disease, as pulmonary tuberculosis frequently is reputed to be, acting as a sudden unpleasant stimulus, will necessarily produce a corresponding reaction in the individual profoundly affecting his future behavior. This is not surprising in view of the fact that life's demands and the privations of the disease are pretty constant factors. Dr. Silk writes:

> "My own observations of various classes lead me to believe that the great majority of patients show a distinct depression following the diagnosis of the disease, but not any more than would be natural under a serious situation; however, as time goes on and the disease runs a chronic course causing little discomfort, they soon make certain adjustments, become partially reconciled, modifying their lives and making plans for the future compatible with the disease. That they are too optimistic is absolutely untrue. The great majority of patients of ordinary intelligence fully realize their condition, but they hope that under certain conditions they may live for many years and this is not unreasonable in view of the hope held out by physicians."**

Fear of the disease seems to be one of the mental traits frequently found in individuals suffering from tuberculosis. Dr. George Stevenson also finds this trait among patients who have doubts about their health. "Secret fears, especially of tuberculosis, syphilis, cancer, and heart trouble, are extremely common, and a patient must expect his doctor to try to find out why the fear arose in the beginning and why, perhaps, it is adhered to in spite of evidence to the contrary."† Anything that produces nervous exhaustion lowers the vitality of the individual and renders him susceptible to tuberculosis. Fear is a powerful factor in producing both.

### EFFECT OF JARRING PERSONALITIES

The effect of emotions on the physical condition has long been recognized by physicians. Dr. John Hunter, the famous eighteenth century anatomist and surgeon, when he was sick with angina pectoris and realized the powerful influence any psychic disturbance would have upon him, is reputed to have said, "My life is in the hands of any rascal in London who chooses to take it."†† This is

*Presented before the Conference of the Mississippi Valley Tuberculosis Association, Kansas City, Mo., October 6, 1933.

**"The Psychical Changes Observed in Pulmonary Tuberculosis and Its Relation to Insanity." S. A. Silk, Ph.G., M.D., Med. Record, Dec. 8, 1917.

†"On Being a Patient," George S. Stevenson, Mental Hygiene, Vol. XVI, No. 1, January, 1932.

††"Environment and Resistance in Tuberculosis," Allen K. Krause.

the environment of personal association —of antagonistic personal association in particular. Every physician is aware of the enormous amount of functional disturbances which the reactions of jarring personalities bring into being. There is a social environment of good fellowship, contentment and happiness which may exist in physical surroundings far from meeting our accepted standards of hygiene and yet its effect on the general well being of those satisfactorily situated in it is favorable. There is also a radically different environment of incompatibility, oppression and antagonism. It may be found where food, sunlight and air leave nothing to be desired; yet even here it will be a contributory factor in physical ill health. Dr. R. C. Cabot has written concerning this subject:

"Although physicians have for centuries cherished the ideal of 'getting to the bottom' of the patient's troubles, of avoiding superficiality and plunging as deep as they could towards the basic cause of his illness, yet they have been inclined, both by their temperament as a profession and by the nature of their training, to focus attention upon the bodily manifestations of disease and to ignore partially or wholly the intelligence, the emotions and the will of the patient, together with the effects made upon him by his relationships to his family, his friends, his work, his recreation, his religion or lack of it, and the other influences entering his life. There is nothing new in the recognition that a patient may suffer from disturbances of his stomach, his intestines, his heart and other portions of his anatomy all because of wounds of the spirit, fevers of the mind, moral degenerations, fatigues, sorrow, remorse, worry. There is nothing new, I say, in this knowledge, but even yet it has penetrated into the practice of only comparatively few physicians. Though our medical text books tell us all these facts, we forget them because our senses present us such impressive evidence of bodily disease and because on the whole our medical training centers our attention there and nowhere else."*

#### WHO AND WHAT IS THIS PATIENT?

Although this is all well known, attention to the existence of fear, anxiety and unsatisfactory personal relationships is comparatively recent, but it is taking an increasingly prominent part in adequate medical treatment.

The only right way to understand the wherefore and why of the psychology of the patient and his mental traits is the genetic approach—which considers the individual at any given moment in relation, not only to what has taken place since his first day of coming into the world, but also what has preceded him, racial and other phylogenetic characteristics. The realization by an individual that he has tuberculosis brings him face to face with one of the most serious problems he may ever be called upon to encounter. He must meet such a difficulty by many new adjustments and must adapt himself to many new conditions and environments and, just as healthy individuals react differently to the same stimuli, so the tuberculous patient is no exception and shows just as many reactions and different forms of adaptations to his changing situation. The difference lies in the individual's past experience and the way it has sensitized him to problems. The manner in which he has met other difficulties during his life will indicate to a certain extent how he will meet the present crisis. There is no formula that will tell how a certain life experience will affect a given person. Only an individual study designed to reveal one's personality developments in relation to a given illness will bring out the connection. The social worker has to deal with the patient as a whole, living human being, whose personality and outlook on life are the outgrowth of past and present joys, sorrows, hopes, successes, discontents, quarrels and friendships. These things all influence the spirit in which a patient responds to his doctor and the doctor, nurse, and social worker should deal with them. The patient cannot be a mere onlooker, he must play an active part. His ability to do so depends very much on his mental health and this phase of his health needs to be tested and the defects in it brought to light because they influence his relations to his physician and the course of medical care.

#### MUCH DEPENDS ON THE PATIENT

Every patient presents an unique per-

*"Hospital and Dispensary Work," Richard C. Cabot, M.D., Hospital Social Service, Vol XVIII, No. 4, Oct. 1928.

sonality for study and within each there resides to a great extent the means for solution of his problem. During the process of interpreting to the patient the implications of his condition and the physician's recommendations for treatment, there is opportunity for the medical social worker to learn his emotional state, to foresee his probable reactions to the proposed care, and to influence his attitude regarding treatment. If the interviews are skillfully conducted, the patient will thus in a measure reveal himself, just what his habits of thinking, feeling and acting have always been. With knowledge of the patient's past history or life story, his habit patterns, his present emotional state and environmental condition, it is then possible for those concerned with his care to modify adverse attitudes and to plan for the maximum of treatment with the minimum of disturbance of the individual's normal activities.

Public health nurses and medical social workers should be depended upon to make this careful personality and environmental study of each tuberculous patient in order to supplement the understanding of the patient which the physician obtains in his usual necessarily brief examinations. It is their function also to help the patient to gain some insight into his attitudes and reactions and to secure his coöperative participation in treatment. In no other chronic disease has more emphasis been placed on the importance of securing satisfactory responses and reactions from the patient than in tuberculosis. It has been stated by Dr. Pollock, "Those who deal with the tuberculosis problem know only too well that we could save and prolong many more lives among the tuberculous, even without the further improvement of our specific remedies, if we could receive a heartier coöperation among our patients."*

### A RADICAL CHANGE IN THE ROUTINES OF LIFE

The first recommendation is invariably complete rest from all physical and mental activities, which usually means a radical change from the patient's usual way of life in almost every phase, family and home responsibilities, work, sex life and recreation. Mental relaxation is as essential as physical rest. When the nurse or medical social worker understands the patient's emotional reaction to the knowledge that he has tuberculosis and to the treatment plans, she is in a position to aid him in making the necessary adjustments. Some release of emotional strain may be accomplished through the opportunity of discussing with the social worker possible plans for relieving him of home responsibilities and securing the economic security of his family. If the patient is the wage earner, assurance must be given that wife and children will be cared for during his absence while in the sanatorium. If the patient is a mother, she must be given some satisfactory evidence that her children and home will not be neglected while she is unable to care for them. When the application list for sanatorium care is long and patients must wait months for admission, there are such problems as rearrangements of living conditions, supplementing or provision of income, supervision of bed rest, instruction regarding protection of contacts, etc., which must be carried concurrently by the public health nurse and others.

### UNDERSTANDING THE NEW ROLE OF PATIENT

Physicians know how hard it is to enforce a rigid sanatorium régime on their patients. Frequently when they obey strict institutional rules they are subdued rather by force than by the wholehearted acceptance of therapeutic measures. Also, the statistics of many tuberculosis sanatoria show that patients are frequently discharged against medical advice before treatment is completed. This means that much of the anticipated result of good medical care is dissipated by a too early return to the strains and stresses of life outside an institution. There is no satisfaction in the assump-

*"The Psychopathological Aspects of Tuberculosis," Medical Journal and Record, N. Y. CXXV, 1927.

tion that once the importance of rest is explained to and impressed upon our patients that it is up to them to decide for themselves whether they wish to recover from the disease or not when they obey or disobey their physician's recommendations. It is obvious, if the tuberculous patient is to be restricted in his physical activity, that much thought must be given to providing means and methods by which attitudes may be influenced and outlets provided for energies inborn in every human being. It is the function of the medical social worker to help the patient gain some insight into the emotions which are dominating him in his reactions to medical advice. She must assist him in seeing himself objectively. Much will have been accomplished if she can give him some insight into the utter foolishness of any selfish, reckless jeopardizing of his own and his family's welfare. Yet the patient frequently rationalizes his act by insisting upon his family's great need of him. To a responsible person, dependence on charity and the loss of power to direct his own and his family's affairs is a hard thing to which to submit. Absence for months or years may tend to make him feel that he is permanently losing his position of respect and responsibility within the family group.

Through understanding the patient's emotional processes, the worker may discover the means or modes of approach whereby she may help him develop an increased capacity for self-direction and an acceptance of himself and his total situation. If this is accomplished, the patient is then somewhat prepared for the difficult problems which he must face when he returns to family, industrial and community life after sanatorium care is completed.

### WORKING WITH THE FAMILY DURING THE "CURE"

While the patient is still in the sanatorium, a constructive attitude towards his situation should be built up in his family and friends. Their influence will be valuable in persuading the patient to remain in the sanatorium and in adjusting him to the social and environmental problems which confront him upon discharge.

Of particular concern is the attitude of the patient regarding marital relationships. Occasionally some patients develop the reckless attitude of grasping any pleasures which they can, irrespective of the possibility of infecting others and reducing their own resistance. Jealousy and suspicion of husband and wife, as the case may be, are not uncommon reactions. In these instances the social worker needs to interpret the patient's emotional reaction to husband or wife and gain cooperation in making the patient feel that he or she is still an important member of the family group.

### OTHER CONCURRENT PROBLEMS

There are many other phases of medical social case work with tuberculous patients which have not been indicated within the limited range of this paper. There is the problem of the patient who shuts out reality and resents very much the physician who tells him an unpleasant truth. His attitude is, "If I have tuberculosis, I don't want to know it." Some patients have a tendency greatly to overdo the physician's advice or else to disregard it or even do the opposite by way of convincing themselves that they are not as badly off as the physician thinks. There is the period of convalescence during which a patient is faced with the necessity of seeing his family again become nonchalant about him, regaining confidence in his own physical integrity and attempting to fill a position in the industrial world. Some patients try to take advantage of the sympathy their illness has created and decide that the world owes them a living. All of these problems may require for their solution skilled medical social study and treatment.

The tuberculosis picture of 1933 presents the need for extension of case work technique to the individual patient with tuberculosis in addition to such social measures as promotion of better housing and sanitation, improvement of industrial hygiene and standards of living, and provision of adequate facilities for

the examination and treatment of the tuberculous and those exposed to the disease. It is believed that health campaigns, crusades and broadcasting are more effective when followed by case work with individuals and with situations in which individuals are interlocked. This individualized treatment as opposed to mass treatment, we should be prepared to render. Social case method emphasizes what is unique, singular, special among individuals while mass method emphasizes what is common to many and general.

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# Follow-up Care of the Tuberculous Patient

By GERTRUDE BEDELL, R.N.

THE tuberculous patient, discharged from the sanatorium as "unimproved", represents as a rule only a problem in nursing and hygiene. It is not hard to instruct a family in proper disposal of sputum, disinfection of dishes, and periodic chest examinations for all "contacts" when they have before their eyes an example of how the disease can destroy the human body. But the patient discharged as "improved" or "quiescent" presents more difficulties. To the nurse or tuberculosis worker falls the task of helping him readjust himself to a normal community life, and of aiding him to reassume gradually the burdens he shed upon entrance to the sanatorium.

Institutional life is safe. The buildings, staff, diet, rules are all regulated with one end in view—the arrest of tuberculosis. There is no chance for deviation from hours of arising, afternoon rest, and lights out. There is the advantage of doing what the other fellow is doing which is always easier than plotting one's own path. In a sanatorium, no stigma is attached to tuberculosis because everyone has it. The patient is lapped around, physically and psychologically, with safeguards.

Consider his position when he leaves this protective shell. If he is a moderately or far advanced case, it may take years of careful living to consolidate his cure. He has gained much weight, has a good color, and, to the eyes of the uninitiated, he is perfectly whole. The patient knows better, but his family does not. Here is where education is needed, and the nurse must be the teacher. She should tell Mrs. Smith that her husband's outward appearance does not mean that his lungs have improved in the same degree, that only a physician can tell a patient's chest condition, that the cobweb delicacy of the fibrosis which constitutes healing may be destroyed by the lifting of a single heavy object, that it will be some time before the patient can disregard the need for as much rest as possible. Mr. Smith may have already told his wife this, but often the corroboration of a stranger and a nurse is needed to make her believe it. Leaving booklets like "What you should know about tuberculosis"* and "Coming home from the sanatorium",* is a good clincher to the talk.

### VISIT AS SOON AS POSSIBLE

The visit is best made as soon as possible after the patient's return home, for it is important to get him started on the right path. Tell him to continue the sanatorium régime as far as he can in his home surroundings. Give him a card with the name and place of chest clinics marked on it, and tell him to come in for an examination at the end of three months unless he should develop symptoms which would indicate an earlier return. Advise him about the disposal of his sputum, even if it is negative, and see that sputum cups are provided.

In this time of economic depression it is probable that the patient's diet at home is neither as plentiful nor as nour-

*Published by the National Tuberculosis Association, 450 Seventh Avenue, New York.

ishing as it was in the sanatorium. A weekly $3.25 food order from the "E. R. A." cannot be stretched very far, especially if there is a child to share the quart of milk which accompanies it. The patient who has been accustomed to drinking eight glasses of milk daily at the sanatorium, fears, with reason, that he will lose weight. The nurse, by explaining the case to the "E. R. A." head in the community, or perhaps getting a statement from the doctor, can arrange for a larger food order and an extra supply of milk. A friendly talk, printed material on low cost diets, available from many welfare agencies, will help furnish an adequate diet.

If the patient succeeds in finding a job, urge him to have a chest examination before beginning it, and to talk over with the doctor the amount of exertion the work requires. Impress on him the necessity for resting all the time he is not working, and make him realize that you understand and appreciate the will power needed for the quiet life. A recovered patient can work and rest, or play and rest, but he cannot do all three. Point out that careful living for the next few years will pay him health dividends all the rest of his life. Dancing, ball playing, swimming, tennis, or any exercise causing sudden strain is dangerous, and should never be attempted except with the permission of the doctor.

Have the wife and child examined every six months for a period of two years. If carfare is lacking for them to get to the clinic, this can usually be furnished by the local department of public welfare, or the emergency relief agency in the state.

#### CHEAPER TO KEEP HIM WELL

The follow-up program for sanatorium graduates is important from a financial as well as humanitarian standpoint. The aim in view is to restore a patient to economic self-sufficiency, to make him once more a contributory member of society, and for this, fairly close supervision is necessary. The cost of his stay at the sanatorium was met out of county or state funds. If he is allowed to sicken again, there is a second cost, and if he dies, his dependents will have to be taken care of either locally or out of the widows' pension fund. In any case the taxpayer pays. It is far cheaper to help the man remain well, than to support him in illness and his dependents after his death.

The attitude of the nurse or worker means a great deal in the help she is able to give. If she can picture herself in the same situation as the patient, and then do something tangible to help him, she will be doing all that can be accomplished in our present stage of social progress.

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## "STUDENT NURSES—MEET THE BOARD!"

An experiment in presenting the questions of board organization and the use of lay groups to students was tried out recently when Miss Evelyn Davis of the N.O.P.H.N. staff held an institute on this subject for the postgraduate students in public health nursing at Vanderbilt University, Nashville, Tennessee. These institutes are usually conducted for the lay groups themselves and this is the first time that a student group of public health nurses has participated in such a program. The three sessions held were devoted to Board Organization, Lay Committees, and Volunteer Service. The interest and enthusiasm manifested by the students as well as by the members of the faculty who attended, made the project more than worth while and made some of us wonder—"Why haven't we done it before?"

# A Quiet Hour in the Health Office

By MRS. VIRGINIA CHAMBERS

*This description won third prize in the recent Radio Sketch Contest conducted by this magazine*

*Scene:* Health Office.

*Time:* 9 a.m.

*Characters:* Dr. White, local Health Officer, Secretary, local doctors, school teachers, and community at large.

(Door opens and Secretary enters).

*Secretary:* Good morning, Dr. White. I hope we have a nice, quiet morning. That report simply must be finished up by noon today. (Sound of typewriter).

(Telephone rings).

*Secretary:* Health Department, secretary speaking. . . Yes, I'll tell Dr. White. Good-bye. . . . Dr. White, Mr. Blank, down on the Emerson Road, says a car struck a dog and killed it three or four days ago, and it is lying right in front of his house and the hot sun is making it terrible. He says for you to come down and move it away.

*Doctor White (sotto voce):* Tell him to move it himself. We don't smell it.

(Typewriter) . . . . . .

('Phone) . . . . . .

*Secretary:* Health Department, secretary speaking. Why, yes, Dr. Brown, we have a prenatal clinic every month, on Tuesdays, beginning at 10:00.

(Typewriter) . . . . . .

('Phone) . . . . . Yes, this is the Health Office. Yes, Mr. School Principal. If the children have a scar showing that they have been vaccinated, we can give them certificates. All right, send them to the office. Good-bye.

(Typewriter) . . . . . .

('Phone) . . . . . Yes, this is the Health Office. No, Dr. White has gone out. Can I take a message? . . . . . Why, yes, we are having the toxoid clinics again this year—in October. We have had hundreds of schedules printed and will give them out at the County Fair, send them to the teachers and have it printed in the county papers. No, it does not cost you anything at all . . . . . Yes, preschool children over seven months of age can come in for the treatment also . . . . No, it will not be necessary to come but one time, as we are using the alum precipitated toxoid this year—a new preparation, and only one treatment is necessary . . . . No bother at all. Good-bye.

(Typewriter) . . . . . .

(Knock at door).

*Colored patient, woman:* Is de doctor in?

*Secretary:* No, I'm sorry, Dr. White won't be back for some time. Can I do anything for you?

*Patient:* Well, Miss, I just don't know if you can or not. Dr. Jones has always been my doctor but this time he tells me to come to see if de nurse can git me in a hospital . . . . My ole man ain't had no work 'cept a day or so at a time for so long that we just ain't got no money to pay nobody, and the children need close and shoes. . . . . I got ten and dey all need closes, and so I just come to see de nurse . . . . Yassum, I got the letter saying come to the prenatal clinic but I ain't got no way to git here.

*Secretary:* All right, I'll give your name to the nurse and she will come to see you and see what can be done. The hospitals are all crowded and quite a number have had to close the free wards, so I can't promise that we can get you in, but we will do what we can to help you. . . .

(Typewriter) . . . . . .

('Phone) . . . . . Health Department, secretary speaking. Yes, the Health Officer does take samples of water for bacteriological examination. What seems to be wrong with the water? You found a dead animal in it? What

kind of animal? . . . . You say it was so badly decomposed you couldn't tell what it was? . . . . All right. Dr. White will try to get there sometime this afternoon. Do not use the water. Good-bye.

(Typewriter) . . . . . .

('Phone) . . . . . This is the Health Department . . . . Yes, Dr. Brown . . . . No, Dr. White is away from the office . . . . Possibly I can get in touch with him . . . . The two Smith children have scarlet fever? . . . . in school yesterday . . . . taken ill at school . . . . Very well, Dr. Brown, I'll get Dr. White over sometime this morning. Good-bye.

('Phone) . . . . Operator, please get me Dr. White up at the Lowland School. . . . . Hello, Dr. White . . . . This is the office. Can you come by the Smith's on your way home and quarantine them for scarlet fever, and also stop by the Pine Ridge School and inspect the children? The Smith children were taken ill in school yesterday morning . . . . Yes, Dr. Brown just 'phoned the report in . . . . All right, Dr. White. . . . Good-bye.

(Typewriter) . . . . . .

('Phone) . . . . Yes, this is the Health Office . . . . No, Dr. White is not in just now . . . . I hardly think he will be back before noon . . . . Can I take a message for him? . . . . You say you sent the children home with impetigo and the parents sent them back? . . . . All right, Dr. White will come up tomorrow morning at 9:30. Good-bye.

(Typewriter) . . . . . .

('Phone) . . . . Yes, this is the Health Office . . . . Yes, Dr. White is the Health Officer. No, I'm not the nurse, I'm the secretary, but I can give Dr. White a message for you . . . . Yes, blood tests are made for certain diseases . . . . I don't quite understand what you mean . . . Just tell me what you want the blood test made for. . . Oh-h-h, I see—to prove the paternity of the child . . . . Well, I'm afraid that wouldn't come under the jurisdiction of this office. Who told you we would? . . . . Well, your husband's brother's sister-in-law was mistaken . . . . Good-bye.

(Typewriter) . . . . . .

('Phone) . . . . Health Department . . . Yes, Dr. Jones, we have smallpox virus . . . . Yes, I can get you a supply on this afternoon's mail and that will reach you tomorrow morning . . . . No trouble at all, Dr. Jones. Good-bye.

I wonder when that report *will* be finished! And I thought it would be "a nice, quiet morning"!

## LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR FEBRUARY

| | |
|---|---|
| Pneumonia | Otto C. Yens, M.D. |
| Nursing Care of Pneumonia | Dorothea Sewell Yens, R.N. |
| Mustard Packs | Madeline Schukar, R.N. |
| Stupes Simplified | Q. B. Mills, R.N. |
| A Suspended Drainage Bottle Holder | Daisy Dean Urch, R.N. |
| Social Trends and Nursing Organizations | Mary Stewart Blair |
| Vocational Opportunities for Men Nurses | Frederick W. Jones, R.N. |
| Opportunities in Graduate Education for Men Nurses | Frances W. Witte, R.N. |
| Nursing and Health | John Sundwall, M.D. |
| Clinical Courses Available to Graduate Nurses | |
| Autotransfusion | Carol M. Nelson, R.N. |
| Public Health in the Nursing Curriculum | Amelia Grant, R.N. |

## A HINT FOR MR. FORD

The Hercules Cycle and Motor Co., Ltd., found a good way of celebrating the birth of their 3,000,000th bicycle on November 23, an output which has established a record not only for the company but for the world. To mark it they have presented fifteen of their bicycles to the Queen's Institute of District Nursing.—*The Nursing Times*, London, Dec. 16, 1933.

# Health Work in a Chinese Community

By MARY ROBERTS MOY, R.N.

TO the Boston Tuberculosis Association goes the credit for a very interesting piece of public health work in the Chinese community here. One Association has been responsible for the beginning of medical work exclusively for the Chinese in this city; the finding of cases of active and incipient tuberculosis who are receiving no care or are in need of preventive treatment, and the employment of a Chinese public health nurse—myself—to do home visiting, teach home hygiene classes and help at clinics.

I will try to give a brief description of the Chinese colony in Boston. On about six streets in the crowded part of the city in the wholesale garment district and close to the roar of the elevated trains, there are groups of three-story brick tenement houses. In this quarter are many attractive Chinese restaurants which are well patronized by American people. Then there are the Chinese merchandise and grocery stores, also a few men's club houses all of which are a part of the life of the colony.

It is here that the Chinese people make their homes on the floors above the stores. A home has about four rooms that are usually crowded. Some of the homes have beautiful teakwood tables inlaid with mother of pearl and American furniture all in the same room. Many present a very gloomy appearance. There is no room for gardens of any sort. There are only two trees in the neighborhood.

The residents are quite limited economically. The majority are from a farming district near Canton in China, and there are only about three means of livelihood for the unskilled Chinese in this country: the laundry, the restaurant, or Chinese merchandise stores. Most of the professionally trained people go to China as it is there that greater opportunities are found. Another great handicap is the fact that immigration laws are very strict, the purpose being to protect American labor. No Chinese person can become a naturalized citizen as Europeans can, so that many privileges are denied an Oriental not born in America.

They are an independent, peace-loving people. They have felt the press of hard times as badly as other people, but none of them are receiving aid from the city. The women are devoted mothers and are kept busy with families of three to six or more children.

The Boston community has about 5,000 residents; 500 of the population are children. There are many workmen in this country without their wives and families. The proportion of Chinese women is very small.

### PRINCIPAL SOCIAL ACTIVITIES OF CHINATOWN

*Chinese Y.M.C.A.*—This is a branch of the large central American organization. It has a very clean up-to-date building and many social and athletic activities take place here that are of benefit to the boys and young men. Every Sunday religious meetings are held, many of the men who attend are out of town laundry workers who come to Boston on Sunday. The Boston Tuberculosis Association has given health programs at the Sunday meetings quite often during the season. The Chinese leader is a college man of very broad understanding. He has been influential in sending many patients to the medical clinic operated by the tuberculosis association.

*Chinese Mission*—There is no church in the community which the Chinese call their own except this missionary center. It is a very old organization and fills a real need in the neighborhood. It gives the children a chance to go to Sunday school for religious instruction. The ladies of the colony meet here every Friday afternoon for their Bible lessons. Individual instruction is given in Eng-

lish to beginners, young men who have just come from China find it a great source of help. There is an active troop of Girl Scouts who gather Saturday nights for their meetings.

*Chinese School*—This is a private school so that the children can learn something of the literature, history and old culture of China. Also Chinese reading and writing are taught. The school is in session all the year after American school is over and there are classes on Saturday morning, so the Chinese children do not have much time to play.

*Chinese United Association*—This is a private court where laundry men appeal to settle disputes.

*Chinese Relief*—This is limited to family clubs. Assistance will be given to needy members if dues have been paid. There are often families who seem to be in very poor circumstances, but no one has been found without food or clothing of some sort.

*Denison House*—This is one of Boston's very old settlement houses. It is a very busy place because it serves a varied neighborhood of Syrians, Chinese and other special groups. There are classes, clubs and recreational activities going on every day. It was at this settlement house that Amelia Earhart Putnam, our famous woman flier, was once a social worker.

#### WHY THE PROGRAM WAS STARTED

To tell of the contribution of the Boston Tuberculosis Association toward better health in this community is not so easy. Our work is in its infancy. This is the first time in the history of Boston's Chinatown, that a place has been set aside especially for medical work among the Chinese. There were four reasons for starting a public health project in this district of the city:

*Chest Clinic: Usually the patients are men; this was a special clinic for young girls.*

1. The last vital statistics report showed that the Chinese colony had the highest death rate from tuberculosis of any section of Boston.

2. Other Boston social agencies had more work than could be handled in this depression era.

3. Many of the men who may have con-

tracted tuberculosis are laundry men or restaurant waiters who could be a source of possible infection to the American public patronizing their places of business.

4. With the policies of the Boston Tuberculosis Association in mind, the work seemed a very urgent duty of this organization.

Important objectives in this work are to give information concerning tuberculosis to the general public; to do educational work in neighborhoods especially susceptible to the disease; to teach through clinics, home hygiene classes, mothers' clubs, and children's camps that suffering and loss of life are needless if treatment is started in time.

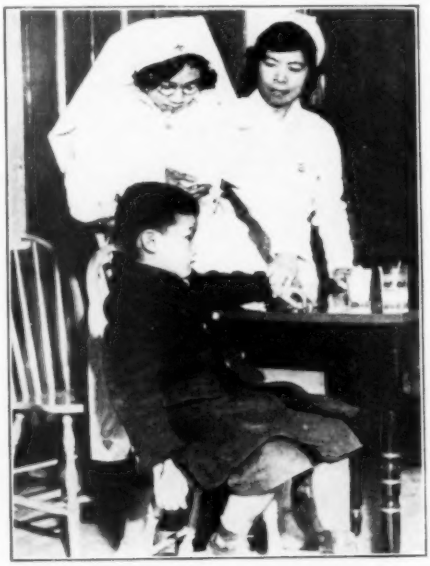
### PECULIAR PROBLEMS

Our problems in Chinatown were very great from the start. There are the differences of race, traditions, customs and language. The community is old, the people are conservative and do not adopt new ideas quickly. When they are sick, they go to Chinese herb doctors as they are much cheaper than those trained in Western medicine. When the herb doctor does not give satisfaction, the patient goes to an American doctor, but does not feel financially able to continue for long repeated treatments. Some of the people of Chinatown like the idea of having us to come to for advice.

There are several other reasons why it is hard to secure coöperation from this group. There is the fear of becoming involved with the immigration authorities; religious scruples and superstitions among the non-Christians which keep them backward; a great dislike of consulting a doctor unless very sick; fear of American hospitals and the possibility of being sent to one as a result of attending our clinic; personal dislike and suspicion of strangers.

Securing a location to hold a clinic was easy as the Boston Tuberculosis Association maintained a workshop in the Chinese neighborhood for convalescent patients. Here women do high grade needle work and the men carpentry and cabinet making. The building used is one of the old school houses which the Mayor of Boston has given us the privilege of using. It was entirely renovated, and it is in a section of this building that the Chinese division of the work is carried on.

The clinic room does not look like a doctor's office. There are colorful draperies and furniture. Attractive health posters hang on the walls. There are several in Chinese writing which indicate good luck and long life. There is a spacious waiting room and never any crowding as in so many clinics. Many times patients will come with friends so



*Demonstration at Graduation Exercises: Red Cross Home Hygiene Nursing Class for Chinese Girls. Taking temperature, pulse and respiration*

that they can talk over with the doctor this new system of medicine which does not mean that going to a hospital for a rest cure means death. We have a chest clinic on Monday afternoons at four o'clock. This time was decided upon because it was the most convenient time for the laundry men who make up a large number of our patients.

The Chinese population learns of our clinic in the following ways:

Articles which we have published in the Chinese newspaper.

Patients sent by the Chinese Y.M.C.A. secretary.

The Chinese sign which hangs outside the building.

Notices written in Chinese which we place on a public open air bulletin board.
Personal visits made by the nurse.

Anyone can consult the doctor of the Boston Tuberculosis Association free of charge about any sickness, as it was felt at the start of the work that many cases of tuberculosis would be found in people who least suspect it. Men, women and children are given examinations. Those found needing special treatments are referred to the best clinic for their particular trouble; often the nurse will escort them as it gives the timid ones who are not used to going to strange places a feeling of assurance. Sometimes we are able to refer a few patients to private doctors. The city of Boston does chest X-rays free of charge for any resident who cannot afford to pay elsewhere. Many deserving Chinese have taken advantage of this opportunity.

### CLINIC SERVICES

The Boston Tuberculosis Association Chinese medical clinic was opened in April 1932. A chest specialist who is on the staff of several leading Boston hospitals makes our examinations. He is a man of unusual understanding, reassures the patients when they need special attention, so that those whose confidence is won like to return. The clinics have not been large but they are growing. Several cases are doing well under home treatment while other positive cases were hospitalized during the year. It is hoped as time goes on that a fund can be secured whereby patients who have contracted the disease and are unwilling to go to a public hospital can be cared for privately. It might be possible to have a Chinese attendant for this group to prepare their accustomed food. In making comparisons of American and Chinese diets, it has been found that Chinese cooking uses all the foods needed for adequate nutrition with the exception of milk and possibly fruit. The Chinese do not serve desserts very frequently and often finish a meal with fresh fruit.

A Chinese nurse was appointed by the Boston Tuberculosis Association to do the contact and follow-up work among the patients. Also she was on duty to assist the doctor and patients at the clinics. The nurse is a graduate of the New England Deaconess Hospital Training School.

The majority of Chinese do not read English although they may be able to speak a little. Translations were made into Chinese telling of the purpose, time and place to attend clinic. Several hundred copies were made and the nurse visited every home, store, restaurant and laundry. She told about the clinic at this time, urged the people to make a visit to the doctor and left one of the papers at each place visited.

There are several adult Chinese Sunday Schools in the city where men go to study English. All of these were visited by the nurse during the year, a health talk given and information about the clinic offered.

Last year a Christmas party was given to about 100 children. Santa Claus came and there was a large lighted tree. All the toys and some of the candy were donated, so that all had a good time for very little expense. In this effort to spread our good will, we hoped to bring about a better understanding of our purpose in the Chinese community.

Several times during the year, meetings for the school children were held when interesting health programs with motion pictures were presented.

In the spring, plants were distributed for window boxes. This is the nearest approach to gardening we could make as there are no yards in Chinatown.

The social service departments of the large hospitals were visited and informed of our work in the Chinese district. We have at times been able to help them with Oriental patients in making necessary adjustments.

An important piece of work was the instruction of 14 High School girls in the Red Cross Home Hygiene Nursing course. The girls had about 25 classes during the winter. They were very interested in home improvement and prevention of sickness. They learned bed making, bathing a patient, care and

feeding a well baby, bandaging, taking temperatures and other useful information. Formal graduation took place in the spring and the girls were quite proud of their certificates presented by an official of the American Red Cross.

To a foreign community that is reticent by nature, and has a real fear of American institutions these small beginnings are humbly submitted. We hope as time goes on that many people in the community will have more faith in the purpose of the Boston Tuberculosis Association to help them.

## LITTLE AMERICA IN NEW HAMPSHIRE

*Snowbound, 1933 Style*

IT had been snowing hard and the plowers had worked day and night to clear the roads of the twenty-inch snow fall. They were about finished and were looking forward to the first good night's sleep in a week. But no—Nature would not have it! She whispered or ordered the North-east wind to blow, and b'ow she did, for three days and nights sweeping across the fields, burdened with snow which she dumped in the roads. The plow had continued to work, but Nature with a roar undid all. Finally the plowers let the North-easter win the day, not because they wanted to, but because the plow broke under the strain.

Early on the morning of the second day came a call for the nurse in Tamworth from an expectant mother. As the thermometer registered in the twenties below zero, the nurse donned more woolen stockings and snow boots and started out. The drifts were so high in the dooryard she could not get the car out without first making use of her sturdy shovel. In the struggle one of the chains broke, but the nurse managed to get to the garage.

Even the garage was stirred by the North-easter. Everyone was rushing about working on the broken plow or thawing out cars or digging out cars. Knowing the nurse had to be on her way, one of the boys stopped his work and fixed the chain. Village men stamped in and out—the garage being as good a gathering place as the old-fashioned general store. Snatches of conversation were overheard: "The worst storm in years"—"A real old-fashioned winter" — "You can't get through, no one can"—"It's piled mountain high down by the Maples."

Although the nurse liked to listen to the weather prophets she had to be on her way, and so she started off with everyone telling her she couldn't get through. But she had to. Creeping down the road she came upon a scene which stopped the car—four cars stuck in a tremendous drift and the tractor, which had been trying hard to tow them, in solid. Many men were shoveling, trying to keep their ears from freezing and the snow from going down their necks. But the old North-easter blew and blew without a twinge of conscience. Once in a while she would stop to get her breath but in a second would start with renewed energy, blinding the men and obscuring the whole view from the waiting nurse. At last, reluctantly, she turned back to her headquarters.

And then Mrs. J. M. Seeley came to her rescue with the dog team. Tucking the nurse into a reindeer jacket and wrapping plenty of blankets around her, she called to the dog leader, Polly, and away they went. Polly was one of the lead dogs Admiral Byrd had on his previous expedition to Little America and the other dogs had been there too. Racing over the would-be roads, climbing through the snow drifts, the dogs soon carried the nurse to her destination (See picture). Care was given to the expectant mother, while the dogs curled up in the snow for a good rest. Eleven miles were traveled to bring the nurse to the needy mother.

*Beatrice Coutts, R.N.,*
*Public Health Nurse, Tamworth, N. H.*

# Nurse-of-the-Month

## NELLIE SUNDWALL

### Utah

Sometime during my high school days I became interested in public health work. It was probably this interest that helped me in making a decision to enter a training school for nurses.

After graduating from the Holy Cross Hospital in Salt Lake City in 1926, I did special duty nursing for eighteen months. A year's illness interrupted, for the time at least, plans of going into public health work in a college of the western states. Fortune smiled later and I found myself very much wrapped up in public health work, taking a summer school course at Columbia University. Two months spent with the Henry Street visiting nurses gave me an insight into a type of field work that I have later found to be invaluable.

For a year and a half I did school nursing in one of the counties in our state. During the summer of this period I took the Red Cross course in teaching Home Hygiene and Care of the Sick at the University of California in Los Angeles, preparing to teach this subject in the county high school.

In January, 1933, I became field nurse for the Utah Tuberculosis Association, with which I am connected at the present time. For several months my activities were limited to Salt Lake County, which includes Salt Lake City, the largest and capital city of the state. This summer it was decided that by coöperating with the State Department of Health and the local medical societies, a survey of tuberculosis in the state was to be made. It has been my duty to arrange for the clinics which are being held and to do the necessary follow-up work. At present it would be difficult to give any figures regarding the work, as it is far from completed. I can say, however, that the educational part of the program in this state is far-reaching, as is that of other states, as shown by the reports of the National Tuberculosis Association. In parts of the state much traveling is done over desert country while other regions are mountainous. In the extreme south of the state we have almost semi-tropical weather, while in the north it becomes extremely cold—a variety of country and weather to deal with!

Utah is my native state, therefore I am interested in the growth of public health work here. We do not have many public health nurses in comparison with some of the other states and much traveling is required in some districts. Though we are few in number we are strong in purpose and I believe most people—both lay and professional—are fully converted to public health work.

# A State Program of School Health in North Carolina

By GEORGE M. COOPER, M.D.

FOR more than fourteen years a project has been going on in the State of North Carolina which is somewhat unique in school health supervision work. This article is an attempt to set forth a brief description of the enterprise which has been conducted by the North Carolina State Board of Health.

Early in 1915 it was the privilege of this writer to become a member of the executive staff of the North Carolina State Board of Health. My first official title was "Director of the Bureau of Rural Sanitation." At that time an effort was being made throughout the South to do something about the more or less deplorable sanitary conditions then existing in all of the small towns and practically all of the country districts. The director's work in the summer time was devoted to organizing county-wide efforts directed toward the control particularly of typhoid fever and other diseases of that character. During the winter months an attempt was made to inaugurate some system of medical inspection of school children, this also on a county-wide basis. Funds for the carrying on of this work had to be obtained from the county authorities or from voluntary subscriptions by private individuals or agencies in the counties. The director's salary and travel expenses were paid by the State Board of Health, but that was as far as the funds would go. Several physicians and senior medical students were employed for the summer months, and three of these physicians were placed on a full-time basis and moved from county to county in the school inspection work during the winter. Previous to that time there was little or no medical inspection of school service anywhere in the State, with the exception of one or two of the larger towns. By the end of the year 1916 the director became convinced that the work was useless, even as a teaching enterprise, unless some organized, permanent method could be devised to reach more of the parents of pupils needing medical attention; in short, the need for a systematic inspection with a definite system of follow-up work was demonstrated.

### GETTING LEGISLATURE SUPPORT

The Legislature of 1917 was induced to pass a law requiring the examination at periodic intervals of all the elementary school children in the State not less than once every three years. The defect in this law was that no appropriation was made for the employment of physicians to do the work. The law required that a physician make the inspections, but that the county or city must be called on to foot the bills. The work being under the direction of the State Board of Health, but the money coming from the counties, naturally produced a situation in which it was impossible to make much progress. Sufficient work was done, however, to demonstrate again the necessity for a permanent, centralized arrangement financed by the State to encourage and foster this work on a State-wide basis.

The result of the two years' experience enabled us to repeal the law of 1917 and to get the Legislature of 1919 to enact in its place a law carrying out the provisions requiring the inspection at not less than three-year intervals of all the elementary school children, and making an appropriation sufficient to enable the State to employ individual workers to execute the law independently of the county appropriations. The writer was privileged to write this law, which was enacted without material opposition. A requirement was inserted in the law that an "agent" of the State

Board of Health should be employed to do this work. The writer had already come to the conclusion that a thoroughly capable, experienced school nurse could do this work better and more satisfactorily than any other "agent" at the same cost. The nurse would have particular ability in reaching the mothers and teachers as well as in coöperating with physicians in private practice.

### STARTING WITH SIX NURSES

With the background just described and the experience obtained, the writer, whose official designation had been changed to "State Director of Medical Inspection of Schools," employed six competent, well-trained, experienced nurses. This was in the late summer of 1919. All of these six women are with us today. Their work has covered an uninterrupted period of more than fourteen years, and every day of that work has demonstrated the wisdom of the undertaking. Recently, we have added two more nurses in order to increase the force and provide for a longer stay in each county.

In the beginning of the work it was made plain to the nurses and to the State, that they were not physicians, that they were not to undertake to make a diagnosis of the conditions they found among the children; they were simply school nurses engaged in school health supervision work. It was understood in the beginning that they were to regard themselves as representatives of the State Board of Health in any community in which they worked and that any question relating to the advancement of public health was a part of their duty. At the same time, so far as their official connection extended, they were to stick to their specialty. The specialty may be defined as inspection of each individual school child under the seventh grade in every school in the county in which they are sent. This includes children of all ages and races; no distinction has been made between the white and Negro schools. The nurses test vision and hearing, examine the teeth and throat, and weigh and measure each child. They obtain the family history and the individual history of each child relating to immunization, communicable diseases, and so on. They have given talks in every grade room of every school, from the one-teacher school back on the mountain side or remote in the swamps to the large consolidated schools having many hundreds of pupils. They have placed the literature of the State Board of Health in the hands of families needing that particular kind of information at the moment. They have averaged about seventy-five thousand inspections a year during the fourteen years of their work.

### EFFECT OF THE SCHOOL HEALTH PROGRAM

At the time the nurses commenced work there were not more than twenty whole-time county health and city health officers in the State. As a result of their pioneer work and their intensive teaching in a number of counties during the first seven or eight years of their service the number of counties with whole-time health departments was increased to nearly forty. When the organization of a whole-time health department with a physician as head of the department and a nurse and sanitary inspector took place, the school nurse's work was withdrawn. At present there are about fifty-six counties which have no form of whole-time health department work. In these counties the nurses go biennially for the individual inspection of all the school children; and in the same fifty-six counties they go back in the summer time to organize and instruct the midwives, with the aid and assistance of physicians and other socially-minded people in the county, as the director of the Department is also director of the Bureau of Maternity and Infancy.

### GETTING DEFECTS CORRECTED

At the beginning of their service in 1919 the question of follow-up work—that is getting something done for the defective children most needing it, particularly the indigent ones—had been a burning question for several years. In 1918 the director of the Department ex-

perimented with employing a half dozen school dentists to teach oral hygiene, not only in lectures, but to demonstrate with a portable equipment the care necessary for children's teeth. This plan was put on a permanent basis in 1919, the director of the Department directing the work in both fields. The oral hygiene division became so important that in 1929 a whole-time dentist was employed to become a member of the staff of the State Board of Health, and the past winter he had seventeen dentists employed full time under his division. They are primarily teaching mouth health; the repair work done is only incidental, as a demonstration, most of the work being referred to private dentists.

*School Nurses, State Board of Health, North Carolina*

In 1919 the director of the Bureau, with the able assistance of the nurses, organized a system of tonsil and adenoid clinics. This clinic plan was to run for a period of five years as an educational demonstration. Up to that time it had been next to impossible to obtain the consent of parents to have their children operated upon for the removal of tonsils and adenoids, even though the specialists would agree to do the work free for poor people. They were fearful of hospitals, suspicious of specialists of every kind, and constitutionally opposed to leaving their own home communities to take the trip often necessary to a far away city for an operation. Thus the follow-up work in this field was falling flat. The assistance of some of the ablest eye, ear, nose, and throat specialists in the State was obtained. They agreed to operate in these clinics. A small fee was charged those able to pay. The operating surgeon was paid one hundred dollars a day for his work. The maximum number of children operated upon in any one day was placed at twenty-five. A temporary hospital outfit, including modern equipment with army cots and every aid to doing good work, was obtained, put on a truck, and sent from county to county for the purpose of conducting these clinics. The clinics were conducted almost exclusively in counties having no hospital or specialist; the children were referred to the physicians following the nurses' inspections in the winter; the clinics were held in the summer, and the nurses undertook to arrange for care for representative children from all of the remote communities in a county.

Instead of this work ending at the

end of five years, as was planned, due to changes in the State Board of Health organization and to the popularity of the work, it did not end until September, 1931—twelve years instead of five. A total of 23,211 children had successful operations in the clinics, which were held in a total of about eighty counties, with return visits to some of the remote small counties.

Naturally, after the demonstration was thoroughly made and the people of the State from one end to the other understood what a tonsil operation meant, it served to excite the opposition of some of the specialists who were fearful of State medicine, government practice, and so on. The Board of Health recognized the validity of their claim, that a health department has no business engaging in treatment of disease either medical or surgical, and the clinics were permanently discontinued in 1931. They should have been discontinued earlier, but the demonstration remains as one of the greatest teaching enterprises ever carried out in this State.

The success of this work was due almost entirely to the consecrated service of these six nurses. They have taught the benefits of good health to the people of every community in North Carolina. They have traveled on foot, horseback, on rafts, by boat, tram car, ox-cart—any way to reach the "forgotten" child. They have exerted a profound influence on the public health movement of this generation in the State of North Carolina. Reports have come to us from every section of North Carolina this year indicating that more corrective work has been done not only for preschool children but for children of school age, than would have been thought possible even ten years ago. There is hardly a county in the State but has had some organized effort during the past summer to provide medical, surgical, and dental treatment for an increasing number of children. The writer takes pardonable pride in stating that this work is a direct result of the intelligent efforts made by these half dozen nurses and the leaders in the organization of the State Board of Health.

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## WAITER, A CLEAN GLASS PLEASE!

Those of us who snatch a sandwich and a cup of coffee at a lunch counter have, on more occasions than one, looked away from the unappetizing preliminaries to serving our lunch and longed for the assurance that the plate about to be handed us was clean, the hands preparing our sandwich, clean, and the spoons and glasses sterilized "between drinks." That thousands of eating places are not taking even the first step in protecting customers from the transmission of disease is well known to every public health nurse. Now at last something is to be done about it in one city—New York. A Committee for the Study and Promotion of the Sanitary Dispensing of Food and Drinks is starting work by carrying on an intensive educational campaign, and the public is being advised to follow these specific courses of action for its own protection:

Commend the management of eating and drinking places that maintain high sanitary standards.
Demand either utensils that have been thoroughly sterilized or single service containers.
Protest to the management against all insanitary dispensing practices observed.
Report by name and address to the Health Department those places that flagrantly violate high standards of sanitation in dispensing food and drinks.

What may happen when control of food dispensing is lax was tragically demonstrated last summer when amebic dysentery broke out in Chicago and quickly spread to more than one hundred communities in the country. The outbreak of this disease was traced directly to food handlers in a Chicago hotel.

Further information on the aims and plans of this committee can be obtained from its offices, 450 Seventh Avenue, New York, N. Y.

# Health Education in the Junior High Schools *

By EDITH K. MORRISON, R.N.

HEALTH education in the junior high school will be better understood if we look first at the background of the picture and examine some of the underlying assumptions of the newer trends in educational theory, and the nature and scope of health education in general.

The psychological conceptions which control educational practices are directly opposed to the theories of mental growth and development which have until recently had a dominating influence on the textbooks and in the planning of the curriculum. These older theories, which assumed that mental abilities appear in a serial order and that they are characterized by relatively rapid and abrupt changes, encouraged a definite break in the program between the elementary and secondary schools.

However, recent researches have all tended to confirm the conception of a gradual and parallel development of mental traits. The great mass of evidence lends support to the view that mental growth is a gradual process. The demand now is for a curriculum that is progressively graded from the elementary through the secondary schools.

### WHAT IS HEALTH EDUCATION?

Not only is it necessary to consider these larger aspects of the situation, but we should try to gain a more definite idea of the objectives and scope of health education. The shortest and best definition of this subject states that "Health education is a systematic program for developing the habits, attitudes, and knowledge that will contribute to physical, mental and emotional health." From this definition we see the great objective sought is the full rounded health of the individual, with emphasis on the activities that induce health. Health behavior is emphasized above health knowledge.

When seen in this setting, any well planned program of health education in the Junior High School should build upon the foundation of those health habits and attitudes already formed in the elementary school. In Junior High School, a fresh approach can be made to attain and strengthen those same objectives. A greater emphasis, however, should be placed on the pupil's sense of responsibility for achieving these ends. The reason for health practices can and should be gone into more fully. The problems of health from the social and community point of view begin to have more meaning, while personality problems and mental health become more real at this age.

### USING THE SCHOOL ORGANIZATION

The question of how these purposes are to be realized must be answered by an examination of the school organization in and through which the program for health education must function.

There is, first of all, the health service of the Medical Department, conducted by the school doctor and nurses, whose chief function is to protect the health of the school community. In this health service, consisting as it does of medical examinations, daily inspections, weighing and first aid, continual opportunities for direct and indirect instruction in health are presented. It would be difficult to over-emphasize the value of this form of health education.

The department of physical education, too, has a definite interest in the health of the school. Through its program of physical activities it contributes directly to the children's health as

*Presented at Joint Meeting of South Eastern District School Nurses' Association and New York State Teachers' Association, October 27, 1933.

well as by definite courses of health instruction.

In this setting, with a correlated and progressive program of health instruction on the one hand and on the other, the forces of the medical and physical education departments, we may clearly visualize the problem of health education in the Junior High School.

### CORRELATING SUBJECT MATTER

Health education in the more limited sense of definite health instruction in the Junior High School consists, first of all of health information imparted in connection with the courses in the natural and social sciences.

In addition to these courses which deal directly with health knowledge, such as physiology and hygiene, a very important part may be played by correlating health with the teaching of other subjects. I feel that it is necessary here to utter a warning: The practice of health teaching has often consisted too largely of dragging the subject of health, as it were, by the hair of the head into some lesson on mathematics, or history and to consider that one's duty to the health program of the school has thus been fully discharged. The teaching of health is far too important to be dismissed in this superficial manner. It must be taken seriously and taught scientifically.

In the Junior High School this can best be done by courses in natural and social science. The purpose of correlating the teaching of health with other subjects is to supplement the regular health instruction that is being given, so as to remind the pupils of the health objectives sought, and to encourage and strengthen the health attitudes and habits being formed.

With this in mind, the following methods of correlating health with various subjects have proved most valuable. In general science, for instance, these topics: air, safe water, weather, bacteria, sunlight, animals as sources of food and disease, etc., have all important health implications. In mathematics, graphs of a variety of health data may be constructed. For example, one of the classes is working out graphs illustrating absences for colds. The pupils' weights are also a good opportunity for the making of graphs. Each one of our weight cards has an accompanying graph. With the English classes many correlations may be made. One of the most interesting of these is the school newspaper. Various articles on health are published from time to time. It is fun to be interviewed by an enterprising reporter, and at the same time it gives one a good opportunity to impart a timely health message. Another fruitful field for health correlations is in the study of history. For instance, a study of health ideals of the Greeks may serve as a stimulus to the pupils. The history of the plagues in olden times can be very fruitfully compared with present methods for controlling communicable diseases. There are very few subjects in which correlations with health cannot be made.

### IN SPECIAL PROJECTS

Health instruction is, moreover, given in special projects undertaken by the different classes. In one project with bees, with the hives in the class room, the class studied the subjects of sanitation, cleanliness, and sex. Much interest was aroused by this study. At the present time a pair of birds is furnishing material for lessons on the health topics of cleanliness, food and sex. A health scrap book is a good way to arouse the interest of pupils in articles on health topics, such as accidents, quack medicines, and food. The Physical Education Department in Scarsdale is conducting two projects, Health Week and Posture Week. In Health Week, tags or buttons are to be given to those members of the school that have luncheon trays which show a well balanced diet. Other projects, health plays and puppet shows, have also been given. These benefit other classes as well as those which undertake to create them. Some years ago a health fair was held for several years in succession. Each class was made responsible for a booth illustrating some health or safety lesson.

Besides these regular courses of instruction and special projects, other

means of imparting health information are used. Regular study periods are assigned for the reading of health biographies. Pasteur, Ross, Trudeau, and Koch, are some of the health heroes studied. Simple experiments are sometimes conducted in classes: for example —the digestion of food in test tubes; or the testing for sugar or starch.

Some years ago, after a careful study and comparative analysis of several syllabi of health education programs, the school nurse at the request of the superintendent, compiled a syllabus of topics to be used for reference in teaching health in the Scarsdale schools. This syllabus, which contains a very complete catalog of all the subjects that should be included in health teaching programs has been very useful in furnishing the teachers with the necessary information to have at their finger tips.

## OUR CONTRIBUTORS

We are delighted to identify Dr. Gaylord W. Anderson as the Deputy Commissioner and Director of the Division of Communicable Diseases in the State Department of Public Health in Massachusetts (page 66). He also is an assistant in the Department of Public Health Administration of the Harvard School of Public Health. ¶ Miss Morrison, who is at present the school nurse in the Board of Education in Scarsdale, N. Y., is a graduate of the Pennsylvania Hospital, Philadelphia. She has had public health experience in Philadelphia and New York (page 94). ¶ If it is an advantage to experience what one is teaching, Miss Bedell (page 80) ought to be well prepared, as it was through being a victim of tuberculosis that she took up training. She is at present a worker for the Union County Tuberculosis League in New Jersey, investigating for the county sanatorium, holding school clinics and doing follow-up work among discharged patients. ¶ Dr. Bloodgood offers another of his direct and helpful statements as to one of the common pre-cancerous conditions (page 97). ¶ The third prize winner of the Radio Sketch Contest, Mrs. Virginia Chambers (page 82) is not a nurse. She is secretary and "general trouble man" in the office of the state and county health department at Bel Air, Maryland. ¶ Miss Edith Baker (page 76) writes that she is a graduate of the Simmons School of Social Work, having had experience following graduation in the out-patient department of Massachusetts General Hospital. She is now director of the Social Service Department of Washington University Clinics and Allied Hospitals, St. Louis, Mo. ¶ Miss Moy is an American-born Chinese, a graduate of the Forsyth Dental Infirmary and of the New England Deaconess Hospital in Boston. As her article tells (page 84), she is now the public health nurse for the Chinese community in the health center conducted by the Boston Tuberculosis Association. ¶ Dr. George M. Cooper (page 90) is the Director of the Division of Preventive Medicine of the North Carolina State Board of Health.

# A New Note on Moles and Warts *

By JOSEPH COLT BLOODGOOD, M.D.

*This is the fourth in the series of articles on Cancer*

AS William H. Welch of Johns Hopkins said some years ago: "The byproducts of any educational effort may be more valuable than the effort itself."

This story may be looked upon as the valuable byproduct of educational efforts for the protection of people against cancer: Recently in a great city an educated, well-to-do man, who is in the insurance business, consulted a well-known surgeon about a black mole and a rough wart. The surgeon removed both under local anesthesia in a standard hospital and saved neither mole nor wart for microscopic study. The removal was performed with a new electric needle. A few weeks later the scars were observed when the man was examined for life insurance and when the report was read by the chief medical examiner the man was refused life insurance because neither the mole nor the wart had been subjected to a microscopic examination. Ultimately the facts were referred to me. There is no doubt that when apparently innocent moles have been removed and not examined with the microscope the patients have returned one to five years later with metastasis and have died of cancer.

I have investigated a very large number of cases over a long period of time and with very few exceptions these apparently innocent moles, which have been removed and not studied under a microscope, had shown some growth and some weeping before they were removed. An absolutely quiescent black or pigmented mole, if removed properly, never gives further trouble, and the proper time to remove a mole is before it has given any trouble or shown any growth or weeping. All elevated moles should be removed and all pigmented spots subjected to trauma should be removed. This is the rule to be followed for full protection.

In the case just cited, we advised the insurance company to give this man his insurance because there had been absolutely no changes before the removal of the mole, and the company did so. That the insurance company took its first stand was undoubtedly due to the widespread educational effort of the American College of Surgeons which has promulgated the rule for standard hospitals that all tissues removed in the operating room must be studied microscopically. There is no question that this is a protection to the patient and, though it is an added expense, it is a protection well worth while.

During a recent visit to a splendidly equipped United States Government Hospital, I happened to go into the operating room where the surgeon was removing what appeared to be a mole and a benign wart. When the sections were made, the benign wart proved to be an early basal-cell cancer (the beginning of a rodent ulcer), and the mole was a benign wart pigmented with coal dust. Therefore, everyone should know and the public health nurse should teach that when any skin defects are removed, all or part should be saved for microscopic study.

*Reprinted in part from the Canadian Press Series, written originally for publication by the authority of the Canadian Medical Society and the Canadian Social Hygiene Society and the Ministry of Health.

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Public health nursing and lay groups interested in cancer education will be glad to know that a film known as the Canti Film is available for showing before small or large groups. It comes in two sizes, 8-minute or 40-minute, and in 16- or 35-millimeter, and portrays the development of normal and cancer cells and the effect of radiation on cell growth. It can be borrowed free of charge except for shipping costs from the American Society for the Control of Cancer, 1250 Sixth Avenue, New York City.

# PUBLIC HEALTH NURSING
## What is It All About?

### Suggesting important sources of information for nurses assisting in the Civil Works Services

*Public health nursing is an organized community service rendered by graduate nurses to individuals and families. It is a basically important service to the community at this time. Through boards of health, schools, other official boards, volunteer public health nursing agencies and industries, it helps to prevent communicable disease; it supplies skilled nursing care to the sick in their homes and promotes health through securing the correction of defects and interpreting medical and sanitary procedures. It offers assistance in adjusting family and social problems affecting health. The greatest single factor in controlling communicable disease, including tuberculosis, in curtailing infant mortality rates and in safeguarding the health of the individual, the family, and the community, is—many authorities state—the public health nurse.*

The following information is offered at this time in the hope that the resources of the National Organization for Public Health Nursing will be used to the fullest extent in assisting nurses new to the public health field to acquire a point of view and to use the specific help which a national organization can provide. Any of this material may be ordered from the N.O.P.H.N.*

Current numbers of this magazine will carry articles on all new developments in the field and will add an enlarged editorial department to offer fresh points of view on present-day changes. (For special offers enabling every nurse to own her own copy of this magazine see page 18 of the advertising section in this February, 1934, number.)

#### FUNDAMENTAL PRINCIPLES OF PUBLIC HEALTH NURSING

*Public Health Nursing*, Mary S. Gardner, The Macmillan Company, New York City, $3.00.
Part I. Chapter IV.
Part IV. Chapters 1-4, Chapter 7.
(This and the following book may be secured from public libraries, borrowed by N.O.P.H.N. members from the National Health Library (write N.O.P.H.N.) or from local visiting nurse associations.)

N.O.P.H.N. *Manual of Public Health Nursing*. The Macmillan Company, $1.50.
Recommended for standard use. Part I. Pages 3, 6, 12, 18.

#### OBJECTIVES

(1) In maternity, morbidity and health supervision services
(2) In school nursing services
(3) In industrial nursing services.
Reprinted from PUBLIC HEALTH NURSING. Free.

#### TECHNIQUES

N.O.P.H.N. *Manual of Public Health Nursing* (See above).
Part II, pp. 51-184. Covers techniques in bedside service, care of the sick, maternity service, communicable disease, school nursing, and health supervision. Includes clinic set-ups.

#### RECORDS

Sample sets available: Forms cover general morbidity service, maternity, child welfare, school nursing, and nurse's daily report sheets. Free samples may be ordered direct from Mead and Wheeler, 610 So. Michigan Avenue, Chicago, Ill.

Record Keeping:
N.O.P.H.N. *Manual of Public Health Nursing*. Part I. Pp. 35-39, p. 43.
*Handbook on Records and Statistics*, U. S. Children's Bureau. U. S. Government Printing Office, 5 cents.

#### RELATION TO MEDICAL PROFESSION

*Public Health Nursing, Gardner*. Part I. Chapter 4, p. 43. Part IV, Chapter 7, p. 247.
N.O.P.H.N. *Manual of Public Health Nursing*. Part I. Pp. 8-12.
N.O.P.H.N. *Board Members' Manual*. Part II. Chapter 3. The Macmillan Co., New York, N. Y. $1.25.

#### PERSONNEL POLICIES

*Manual of Public Health Nursing*. Part I. Pp. 22-31. Pp. 32-46.
*Minimum Qualifications for Those Appointed to Positions in Public Health Nursing*. Reprinted from PUBLIC HEALTH NURSING. Free.

*Lists of *all* N.O.P.H.N. publications sent free on request. 450 Seventh Ave., New York, N. Y.

## RECOMMENDED READING

Special reading lists (free) are available from the N.O.P.H.N. on the following subjects:

Communicable Disease (other than tuberculosis and venereal disease—See Social Hygiene)
General Community Organization
Industrial Nursing
Maternity and Infancy
Mental Hygiene
Prenatal Care
Preschool Care
Publicity and Health Education
Rural Nursing
School Nursing
Social Hygiene
Supervision
Tuberculosis.

From these lists the following books and articles are recommended to give essential background information, available from the publishers or the N.O.P.H.N. as indicated.

### GENERAL COMMUNITY ORGANIZATION

*Appraisal form for city health work.* American Public Health Association, 450 Seventh Avenue, New York City. 75c. Standards for measuring city health department work, by Committee on Administrative Practice.

*Appraisal form for rural health work.* American Public Health Association. $1.00. For experimental use in rural public health areas.

*How to appraise public health nursing and outline of apppraisal.* Alma C. Haupt. N.O.P.H.N. 30c.

*Manual of public health nursing.* (Revised and enlarged, 1932). Prepared by N.O.P.H.N. The Macmillan Co., or from N.O.P.H.N. $1.50. Suggested methods which may serve as a guide for public health nurses in all phases of this work.

Red Cross handbook—*Home hygiene and care of the sick.* American Red Cross, Washington, D. C. 85c.

*Public health nursing.* Mary S. Gardner. The Macmillan Co. (1924 edition). $3.00. Authoritative reference on the development and status of public health nursing.

*Rural community.* Dwight Sanderson. Ginn & Company. $4.40. Presents the social, economic, and psychological aspects to be taken into account in rural community work.

### MATERNITY, INFANCY AND PRESCHOOL CARE

*Behavior aspects of child conduct.* Esther Loring Richards. The Macmillan Co., $2.50.

*Between two and six years.* John Hancock Mutual Life Insurance Company, Boston, Mass. Free.

*Child care and training.* Marion L. Faegre and John E. Anderson. University of Minnesota Press, Minneapolis, Minn. $2.00.

*The child from one to six: his care and training.* Publication No. 30, U. S. Children's Bureau, Washington, D. C. 10 cents.

*Getting ready to be a mother.* C. C. Van Blarcom. The Macmillan Co. $1.75.

*Infant care.* Publication No. 8 (Revised). U. S. Children's Bureau. 10 cents.

*Lesson outlines for maternity classes.* East Harlem Nursing and Health Service, 354 East 116th Street, New York City. 35 cents.

*Outlines of standards and methods for health service.* (Revised.) New York Diet Kitchen, 578 Madison Avenue, New York City. 35 cents.

*Prenatal care.* Publication No. 4 (Revised). U. S. Children's Bureau. 10 cents.

*Routines and briefs for mothers' club talks.* Maternity Center Association, 1 East 57th Street, New York City. 40 cents.

*Standards for maternity care.* Children's Welfare Federation, 244 Madison Avenue, New York City. 25 cents.

*Standards for physicians conducting conferences in child health centers.* Publication No. 154, U. S. Children's Bureau. 10 cents.

*Standards of prenatal care:* an outline for the use of physicians. Publication No. 153 (revised). U. S. Children's Bureau. 5 cents.

*Sunlight for babies.* Folder No. 5. U. S. Children's Bureau. Free.

### SCHOOL HEALTH

*Communicable Diseases in Rural Schools.* Rood. Reprint. National Organization for Public Health Nursing. 10 cents.

*Looking Ahead with the School Nurse.* Palmer and Franzen. Reprint. National Organization for Public Health Nursing. 15 cents.

N.O.P.H.N. *Manual of Public Health Nursing.* The Macmillan Company. $1.50.

*Physical Defects of School Children.* James Frederick Rogers. School Health Studies No. 15. Bureau of Education, United States Department of the Interior, Washington, D. C. 10 cents.

*Rural School Nursing.* American Red Cross, Washington, D. C. 50 cents.

*School Nursing—A Contribution to Health Education.* Mary Ella Chayer. G. P. Putnam's Sons, New York City. $2.50.

*Toward Better School Health Programs.* George T. Palmer. Reprint. American Child Health Association, 450 Seventh Avenue, New York City. 6 cents.

*Home Hygiene and Care of the Sick.* American Red Cross, Washington, D. C. 85 cents.

### SOCIAL HYGIENE

N.O.P.H.N. *Manual of Public Health Nursing.* The Macmillan Co. $1.50.

*Dermatology and Syphilology for Nurses.* John H. Stokes. W. B. Saunders Co., Philadelphia. $2.50.

*Some Public Health Aspects of Syphilis.* Talia-

ferro Clark. Venereal Disease Information. U. S. Government Printing Office, Washington, D. C.

*Study Program in Social Hygiene.* Reprints, N.O.P.H.N. Complete Program, 75 cents.

*Growing Up in the World Today.* Emily Clapp. Massachusetts Society for Social Hygiene, 1150 Little Building, Boston, Mass. 20 cents.

*A Vocabulary for Family Use in Early Sex Education of Children.* Catheryne C. Gilman. Woman's Coöperative Alliance, Inc., Minneapolis. 15 cents.

### TUBERCULOSIS

*Rules for Recovery from Pulmonary Tuberculosis.* Lawrason Brown, M.D. Lea & Febiger, Philadelphia, Pa. $1.50. The standard book for helping patients in understanding tuberculosis and its treatment.

*Environment and Resistance in Tuberculosis.* Allen K. Krause, M.D. Williams and Wilkins Co., Baltimore, Md. $1.50.

*Getting Well and Staying Well.* John Potts, M.D. C. V. Mosby Company, St. Louis, Mo. $2.00.

*Childhood Type of Tuberculosis.* H. D. Chadwick, M.D., and F. M. McPhedran, M.D. The National Tuberculosis Association, 450 Seventh Avenue, New York City. 15 cents.

*Tuberculosis Nursing for Public Health Nurses.* Violet Hodgson, R.N. N.O.P.H.N. 10 cents.

*What you should know about Tuberculosis.* Gerald B. Webb, M.D. National Tuberculosis Association, 450 Seventh Avenue, New York City. 5 cents.

### MENTAL HYGIENE AIDS TO PUBLIC HEALTH NURSE

*Discovering Ourselves.* Edward A. Strecker and Kenneth Appel. The Macmillan Co. $3.00.

*Your Mind and You.* George K. Pratt. National Committee for Mental Hygiene, 450 Seventh Avenue, New York City. 30 cents.

*Morale: The Mental Hygiene of Unemployment.* George K. Pratt. National Committee for Mental Hygiene. 25 cents.

*Behavior Aspects of Child Conduct.* Esther Loring Richards. The Macmillan Co. $2.50.

*Normal Youth and Its Everyday Problems.* Douglas A. Thom. D. Appleton-Century Company, New York City. $2.50.

### RURAL NURSING

*Appraisal form for rural health work.* American Public Health Association, 450 Seventh Avenue, New York City. $1.00.

*Rural community and social case work.* Josephine C. Brown. Russell Sage Foundation, New York City. $1.00.

*Development of rural nursing.* Frances F. Hagar. Reprinted from PUBLIC HEALTH NURSING. N.O.P.H.N. 10 cents.

*Developing community responsibility.* Edna Hamilton. Reprinted from PUBLIC HEALTH NURSING. N.O.P.H.N. 10 cents.

*Handbook of information and suggestions on public health nursing for chapter committees on nursing activities and Red Cross public health nurse.* American Red Cross, Washington, D. C. 25 cents.

*Organizing rural preschool conferences.* (Dutchess County, N. Y., Nurses). Reprinted from PUBLIC HEALTH NURSING. 10 cents.

*Planning a county nursing program.* Margaret Reid. Reprinted from PUBLIC HEALTH NURSE. 10 cents.

*Public health nurse helps control communicable disease in rural schools.* Elma Rood. Reprinted from PUBLIC HEALTH NURSE. 10 cents.

*Rural school nursing*—an outline for Red Cross public health nurses. American Red Cross, Washington, D. C. Revised. 50 cents.

*Health on the farm and in the village.* C.-E. A. Winslow. The Macmillan Co. $1.00. Based on a survey of the Cattaraugus County (N. Y.) health demonstration.

### NUTRITION

*Good nutrition at minimum cost.* 25 cents. Also *Food for the family* (revised). Lucy H. Gillett. Association for Improving the Condition of the Poor, 105 East 22d Street, New York, N. Y. 25 cents.

*Feeding the family.* Mary Swartz Rose. The Macmillan Co. $3.75. A well known and reliable text.

### LOW COST DIETS

Children's Bureau, Department of Labor, or Bureau of Home Economics, Department of Agriculture, Washington, D. C., have combined in putting out leaflets. Write for information.

John Hancock Mutual Life Insurance Company, Boston, Massachusetts. Free leaflets.

Metropolitan Life Insurance Company, New York, N. Y. Available from local agents. Free.

### SUPERVISION

*Public health nursing.* Mary S. Gardner. The Macmillan Co. Chapters 3, 4, 5 of Part 4, pp. 187-233. The chief executive; the supervisor; group management. $3.00.

*Executive leadership.* Ordway Tead. Reprinted from PUBLIC HEALTH NURSING. N.O.P.H.N. 15 cents.

*A supervisor on the inside looking out.* Leslie Wentzel. PUBLIC HEALTH NURSING, March, 1933.

*Public health nursing supervisor,* Her Functions and Ideals. C.-E. A. Winslow. Reprinted from PUBLIC HEALTH NURSING. N.O.P.H.N. 10 cents.

### INDUSTRIAL NURSING

American Red Cross *Abridged Textbook on First Aid.* Charles Lynch. P. Blakiston's Son & Co., Philadelphia. 60 cents.

*Public health nursing in industry.* Violet H. Hodgson. The Macmillan Co. $1.75.

*Personal hygiene applied.* Jesse Feiring Williams. W. B. Saunders Co., 1931. $2.25

*Developing health services in small plants.* Violet H. Hodgson. Industrial Relations, July, 1931.

*Health supervision in industry.* Health Practice Pamphlet No. 5, National Safety Council, Chicago, Ill. 25 cents.

**PUBLICITY AND HEALTH EDUCATION**

*Year Round Publicity Program.* Reprinted from THE PUBLIC HEALTH NURSE. N.O.P.H.N. 10 cents.

*Study course in publicity.* Reprinted from PUBLIC HEALTH NURSING. N.O.P.H.N. 10 cents single copies, 75 cents for series.

*The health talk.* Iago Galdston. The National Tuberculosis Association, 450 Seventh Avenue, New York City. 50 cents.

*Fifty-seven varieties of public health nursing news.* PUBLIC HEALTH NURSING, October, 1931, p. 504.

*Loan Folders.* N.O.P.H.N.
- Annual Reports
- County Fairs and Window Exhibits
- General Publicity Information
- Movies
- Plays and Pageants
- Posters
- Publicity Novelties
- Radio

*This outline will be available in reprint form. Free.*

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## CONNECTICUT STAFF NURSES TAKE STOCK

An encouraging sign in public health nursing education is the increasing interest that staff nurses are showing in self-education. Last November the staff nurses throughout the State of Connecticut, acting on the suggestion of the Public Health Nursing Section of the S.N.A., held an all-day conference entirely of their own planning. A representative committee chose and organized the program and made all the arrangements.

On the day of the conference 140 nurses from all over the State met at Hartford eager to participate in the program. A member of the N.O.P.H.N. staff acted as chairman of the morning's session and led the general discussion.

The morning's conference was devoted to "The Old and New Type of Child Health Conference," which included actual demonstrations in dramatic form by the New Haven Visiting Nurse Association staff, followed by a paper written and presented by a staff nurse.

In the afternoon four round tables under the chairmanship of local leaders were held simultaneously on the following topics: Everyday Problems of the Everyday Family; Records; School Nursing; Prenatal Nursing. A concluding session summarized the various discussions and set forth the goals for the coming year.

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

*Edited by* ALMA C. HAUPT

Our readers will be relieved to hear that Miss Katharine Tucker, general director of the National Organization for Public Health Nursing, is slowly recovering from her very critical illness of lobar pneumonia. Although she left the hospital January 6, it will be sometime before she can be at her desk again. Miss Alma C. Haupt, associate director, will be acting general director until Miss Tucker's return.

SOPHIE C. NELSON, *President.*

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The long-looked-forward-to Census of Public Health Nurses in the United States was published in January.* Besides including the countrywide figures on number of nurses, agencies and ratio of nurses to population, it also covers state by state summaries, the rural situation and the types of positions in which nurses were employed. This report should be in every library and should serve constantly as reference material—at least until 1940!

*Fifty cents a copy.

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*49 West 49th Street, New York City*

The N.O.P.H.N. is moving! To bigger, better *and* cheaper quarters on Sixth Avenue at 49th Street, in the block of buildings known as Radio City, Rockefeller Center, or "Roxy's" Music Hall. It is not the lure of the movies, however, that is sending us on the march again, but rather the superior accommodations, the decision of all the other health agencies in the National Health Council to move there, and the attractive rental rate. When the move actually takes place in the Spring, we will publish minute directions on how to find us, meanwhile we are here at 450 Seventh Avenue awaiting your letter or visit.

## HONOR ROLL FOR 1934

"We are very proud of our Certificate of Honor," writes one agency which has just secured the certificate for 100 per cent nurse membership for the third consecutive year, "and we have it framed in our main office along with the certificates for 1932 and 1933."

The certificate for 1934 is in dull orange and has already been sent to 26 agencies. Special mention will be given this year to the state which rolls up the highest number of agencies holding 100 per cent membership in the N.O.P.H.N. This is a chance for the states with many small services, since it is easier to get 20 memberships from 20 one-nurse services than 20 memberships from one large staff. For once the rural states will get a break! The names of honor roll agencies are published each month in the magazine. We hope 1934 will be a banner year, it is a convention year and to all appearances a year that is going to put public health nursing on the map. Help the N.O.P.H.N. to keep it there!

**CALIFORNIA**
***Pittsburg Public Schools, Pittsburg
*San Joaquin Local Health District, Stockton

**ILLINOIS**
*Evanston Infant Welfare Society, Evanston

**INDIANA**
***Public Health Nursing Association, Richmond

**KANSAS**
***Public Health Nursing Association, Topeka

**MASSACHUSETTS**
***Visiting Nurse Association, Great Barrington
***District Nursing Association, Watertown

**MICHIGAN**
*Visiting Nurse Association, Dearborn
***Health Department of Muskegon Public Schools, Muskegon

**NEW HAMPSHIRE**
***District Nursing Association, Concord
***Good Cheer Society, Nashua

**NEW JERSEY**
***Visiting Nurse Association, Bayonne
***Metropolitan Life Insurance Company, Trenton

**NEW YORK**
***North Shore Public Health Nursing Association, Flushing
***National Organization for Public Health Nursing, New York
***Dutchess County Health Association, Poughkeepsie

**NORTH DAKOTA**
*Steele County Department of Health, Finley

**OKLAHOMA**
***Public Health Association, Tulsa

**RHODE ISLAND**
***Smithfield Public Health League, Esmond
***Pawtucket and Central Falls Chapter, American Red Cross, Pawtucket

**TENNESSEE**
**Metropolitan Life Insurance Company, Memphis

**UTAH**
***Metropolitan Life Insurance Company, Salt Lake City

**VIRGINIA**
***Instructive Visiting Nurse Association, Richmond

**WASHINGTON**
**Metropolitan Life Insurance Company, Tacoma

**WISCONSIN**
*Department of School Hygiene, Appelton

***100 per cent for three consecutive years
**100 per cent for two consecutive years
*100 per cent for one year

# TENTATIVE BIENNIAL PROGRAMS

**Washington, D. C., April 23-27**

## JOINT SESSIONS

*Monday:* Opening session, 8:30 P.M.
Invocation
Address by President of the United States
Address of welcome by local nurses and presidents of three national organizations and Red Cross
Award of Saunders Medal
Marine Band.

*Tuesday:* 9:15-10:45 A.M.
What does the public expect from Nursing?
How can the public participate in bringing this about?
Mrs. Franklin D. Roosevelt will present this first topic.

8:30 P.M. The Changing Order of Today as it Affects the Economic World; as it Affects Community Life.

*Wednesday:* 9:15-10:45 A.M.
Changes in the Field of Education
The Changing Order and Nursing.

*Thursday:* 9:15-10:45 A.M.
Health Aspects of Social Legislation
Legislation and the Future of Nursing
4:00 P.M. Dedication of Jane A. Delano Memorial
8:30 P.M. Changing Order and the Hospitals
The Nurse as Interpreter of the Hospital to the Community.

## N.O.P.H.N. PROGRAM

*Saturday:* April 21. 9:30 A.M. All day meeting of Course Directors—Closed

*Sunday:* 9:30 A.M. State Advisory Nurses.
2:30 N.O.P.H.N. Board Meeting—Closed

*Monday:* 11:00 A.M. N.O.P.H.N. Open Business Meeting
Luncheons: J.V.S. Advisory Council
Board and Committee Members —Business Meeting
2:30 Round tables for Board and Committee Members according to size of staffs represented
4:30 Tea for Board and Committee Members

*Tuesday:* 11:15-12:45 N.O.P.H.N. General Session
New Developments in Public Health
New Developments in Social Work
Luncheons: Field Nurses
Chairmen of Lay Sections
2:30-3:45 N.O.P.H.N. General Session
Public Health Nursing Today
(Report of N.O.P.H.N. Survey of Public Health Nursing)
Channels of Improvement in Schools of Nursing, Postgraduate Courses and Public Health Nursing Agencies
4:00-5:30 Round Tables by function of the individual: Laymen, Administrators, Educational Directors and Supervisors, Field Nurses
4:00-5:30 Demonstration of vision testing technique. Discussion of sight-conservation in school health program
5:30 Tea for Board and Committee Members

*Wednesday:* 11:15-12:45 N.O.P.H.N. General Session. Free period for discussion of most pressing problems of the moment —Sophie C. Nelson presiding
Luncheons: School Nursing Section—Business
Industrial Nursing Section—Business
Chairmen of P.H.N. sections of State Nurses' Associations
2:30-4:00 Conference of Presidents of S.O.P.H.N.s
7:00 Dinner, Board and Committee Members: The Board Member as Taxpayer

*Thursday:* 11:15-12:45 N.O.P.H.N. General Sessions
Immediate Public Health Problems
Session I—Maternal and Child Health Acute Communicable Disease
Session II—Nutrition
Mental Health
Luncheon: N.O.P.H.N. Membership Rally
2:30-3:45 N.O.P.H.N. General Sessions
Changing Order and Community Planning
Session I—Combining Public Health Nursing Services
Session II—Keeping the Public Informed
Session III—Personnel Policies and Practices
2:30-3:45. Demonstration of Vision Testing technique
Discussion of sight conservation in school health program

*Friday:* 9:15-10:45 Free periods of round tables by population groupings, and school nurses and industrial nurses, to discuss most pressing problems and plans for the future.
11:15-12:45. N.O.P.H.N. closing business session, election of officers
N.O.P.H.N. Board meeting

For tentative programs of the American Nurses' Association and the National League of Nursing Education, see the *American Journal of Nursing* for February. The entire Biennial program will be published in this magazine as soon as it is in final shape.

*The Titanic Memorial in Washington, D. C., erected as a lasting tribute to the heroes who sacrificed their lives, that women and children might be saved, in the tragic catastrophe of the sinking of the steamship Titanic off Newfoundland in 1912, in which 1,517 lives were lost and 706 saved. Only 20 per cent of the men on board were saved, and 70 per cent of the women.*

## SIGHTSEEING IN WASHINGTON

The nurses who are planning to attend the Biennial Convention will find this information of interest.

An agreement with the Capital Transit Company, Special Bus Department, through Mr. P. S. Ballou, has secured special rates for nurses for sightseeing trips during the week:

Tour of the City including the business and residential sections with stop at Lincoln Memorial, consuming one and one-fourth hours, 60c per capita.

Tour of the interior of Public Buildings including the Bureau of Engraving and Printing, Pan American Union, White House, Old National Museum, New National Museum and U. S. Capitol, also guide fees and consuming three and one-half to four hours, 80c per capita.

Tour of the residential section of the City and St. Albans Cathedral with stop at Scottish Rite Temple, consuming approximately two and one-half hours, 60c per capita.

Tour of the residential section of the City, Franciscan Monastery, Shrine of the Immaculate Conception and U. S. Soldiers Home, consuming approximately two and one-half hours, 60c per capita.

These trips include guide service.

On Wednesday afternoon, it is planned to arrange for an official tour to include Arlington, Alexandria and Mt. Vernon. During this trip the officers and Boards of Directors of the three nursing organizations will place wreaths on the Tomb of the Unknown Soldier and on Washington's Tomb. The bus company will concentrate their efforts on the Wednesday afternoon tour, and assures the Committee that there will be adequate bus service to take as many nurses as may desire to go. The tour will start from the Auditorium.

On the same afternoon, transportation will be arranged to take nurses to Walter Reed Hospital, which is the Army Medical Center of the United States, where "open house" will be kept and the nurses given an opportunity to inspect this beautiful reservation.

The Naval Hospital is planning a demonstration on the same afternoon, but because of its nearness to the Auditorium no special transportation will be planned.

For the convenience of the nurses, there will be bus transportation to the Auditorium for the joint meetings held during the day, and on the evenings of the joint meetings.

Parties coming in to Union Station, either by special train or special car, will be met by buses if we are notified of time of arrival. Transfer service includes transportation from Union Station to the three Headquarter's hotels, and from the Headquarter's hotels to the Auditorium, and is

quoted at 10c per trip; transportation from the Washington Auditorium to Walter Reed Hospital and return, 30c per capita; transportation to the Washington Cathedral on Monday morning, April 23rd, for those nurses who wish to attend the Corporate Communion Service at 7:30 A.M. and return, 40c per capita; the trip to the Shrine of the Immaculate Conception for early Mass at 7:30 A.M., April 27th, and return, 40c per capita.

IDA F. BUTLER, *Chairman,*
*Local Committee on General Arrangements.*

## CONVENTION TRANSPORTATION

Since the January issue went to press, later information reveals that more western railroads will participate in the reduction in fares on the identification-certificate plan. A complete list of these with dates of sale follows:

| *Territory* | Transcontinental Passenger Association and Western Passenger Association | *Dates of Sale* |
|---|---|---|
| Colorado (Julesburg only), Illinois, Iowa, Kansas, Manitoba,* Minnesota, Missouri, Nebraska, North Michigan, North Dakota, South Dakota | | April 19-25 inclusive |
| Colorado (except Julesburg), New Mexico, Wyoming | | April 18-24 inclusive |
| Montana, Oregon (points on O. S. L. RR. only), Southern Idaho, Utah | | April 17-23 inclusive |
| The Canadian Passenger Association, Eastern Lines, The Canadian National and Canadian Pacific Lines from Winnipeg and certain points in British Columbia | | April 19-25 |

*Special note: Manitoba (on Great Northern, Northern Pacific, and M. S. St. P. & S. S. M. Railways, also from Winnipeg via Canadian National and Canadian Pacific Railways).

Round trip excursion fares on basis of one and one-third fare for tickets with limit of thirty (30) days in addition to date of sale have been authorized via the same route in both directions.

For those who wish to use one route going and another route returning, tickets will be sold at rate of one-half of the round trip fare authorized from starting point to destination via direct routes plus one-half of the round trip fare authorized from starting point to destination applying via route used on the return trip.

The following table of rail and Pullman fares is offered for your information:

| *From* | *One-Way Fare* | *Round Trip at one and one-third Direct Routes* | *One-Way Lower* | *Upper* |
|---|---|---|---|---|
| Albany | $13.27 | $17.70 | $ 7.50 | $ 6.00 |
| Atlanta | 22.97 | 30.63 | 5.00 | 4.00 |
| Boston | 16.40 | 21.87 | 5.63 | 4.50 |
| Buffalo | 15.71 | 20.95 | 3.75 | 3.00 |
| Chicago | 27.78 | 37.04 | 8.25 | 6.60 |
| Cincinnati | 20.15 | 26.87 | 5.63 | 4.50 |
| Cleveland | 15.63 | 20.86 | 4.50 | 3.60 |
| Denver | 58.84 | 78.46 | 15.75 | 12.60 |
| Detroit | 21.55 | 28.74 | 6.38 | 5.10 |
| Kansas City | 40.90 | 54.54 | 11.50 | 9.20 |
| Los Angeles | 88.95 | 118.60 | 24.00 | 19.20 |
| Milwaukee | 30.33 | 40.44 | 8.25 | 6.60 |
| Minneapolis | 39.99 | 53.32 | 10.75 | 8.60 |
| New Orleans | 33.50 | 44.67 | 8.00 | 6.40 |
| New York | 8.14 | 10.86 | 3.75 | 3.00 |
| Philadelphia | 4.90 | 6.54 | (Seat) | .75 |
| Pittsburgh | 10.90 | 14.54 | 3.75 | 3.00 |
| Portland, Me. | 20.32 | 27.10 | 8.63 | 6.90 |
| Portland, Ore. | 92.12 | 122.83 | 24.00 | 19.20 |
| St. Louis | 32.54 | 43.39 | 9.00 | 7.20 |
| San Francisco | 88.95 | 118.60 | 24.00 | 19.20 |
| Seattle | 92.12 | 122.83 | 24.00 | 19.20 |
| San Antonio | 53.12 | 70.83 | 12.25 | 9.80 |

# BOARD MEMBERS PAGE

Of special interest to board members are the following items in this number of the magazine:

Page 63. *Supervision*—why it is an economy.
Page 98. First aid to those concerned with Civil Works Service nurses.
Page 66 and page 82 and page 84. For better pictures of public health nursing activities.
Page 81 and page 93. The fillers, as indications of our progress!
Page 104. Biennial plans—see especially board member activities.

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Publicity again! This time in the helpful form of a manual published by the National Congress of Parents and Teachers, 1201 Sixteenth Street, N. W., Washington, D. C., and a correspondence course based on the manual. A registration fee of $1.00 is charged to cover the cost of the study outline, Publicity Manual, and mailing. One of the features which makes the manual helpful is a chapter on "The Press and Publicity."

We quote one paragraph:

"There is nothing mysterious about publicity methods and technics—no hidden, inner secrets to be probed, no magic skills to be acquired. Publicity methods are nothing more than useful, systematized applications of observation and common sense which any intelligent person may master."

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## YEAR ROUND PROGRAM FOR SOCIAL WORK INTERPRETATION

The Women's Crusade was an outstanding success in interpreting social work to the community at large in the 1933 Mobilization for Human Needs. In order that the interest and leadership brought out in the Crusade might not be lost but be increased and continued throughout the year, Community Chests and Councils, Inc., is suggesting that a "Committee on Citizens' Participation," or similar name, be formed in every community, made up of leaders in the Women's Crusade as well as representatives, men and women, of the social work field and of group interests and organizations.

The following types of programs are suggested for local adaptation and expansion:

Study of Present Lay Participation
Year-Round Speakers' Bureau
Know Your City and Group Discussion Courses
Volunteer Placement Bureau.

Outlines for study and discussion of some of these topics have already been formulated and used for a number of years by several national agencies. Community Chests and Councils* will be glad to send such outlines to any interested group.

*1810 Graybar Building, 420 Lexington Avenue, New York.

# SCHOOL  HEALTH

## TREATMENTS IN SCHOOL*

The whole question of making clinical services, including all medical and nursing services of a curative or "treatment" nature, part of the school program, has become increasingly controversial in the last few years. According to Dr. Fred Moore,** Medical Director of Public Schools, Des Moines, Iowa, "Schools vary in their policies from no treatment physically, to rather complete services in appliances, orthopedic advice and treatment, nursing and physical therapy." He states further that "the school is an educational institution and not one of relief. Other organizations should assume responsibility for relief and medical treatment" . . . "Every proposed activity should be appraised for its educational value before being put into practice."

As a matter of fact, most school administrations require that a certain amount (some more, some less) of treatment be given by nurses of their staffs, because of the responsibility taken by the school "for the whole child," particularly during school hours on school grounds. Wherever a large number of children is assembled in one place for so many hours of the day for work and for play, emergencies requiring medical and nursing care will be unavoidable and some amount of treatment on the spot will be inevitable.

### GUIDING PRINCIPLES

Granted, then, that nursing treatments in emergencies are at present still considered a necessary function of the nurse in a school health nursing service, some important guiding principles to be observed are:

1. Use of existing community resources for clinical services to the utmost, rather than attempting to set up special services in the school.
2. Teaching parents and children the use of existing community health resources, including the private physician, for curative and preventive purposes.
3. Bringing out all the possible educational values in this type of nursing service, so that it will be consistent with the educational objectives of the school.

Treatments in terms of nursing fall into the category of "care of the sick or morbidity service"; hence the same objectives stated by the N.O.P.H.N. for bedside care should hold for this comparable type of nursing service in the schools, particularly the following:

To assist in securing early diagnosis and adequate medical care.
To provide supervision and nursing care for patients ill at home.
To instruct someone in the home [or school] to give care.
To teach hygiene and the prevention of disease.

Just as the teaching aspects are stressed in bedside nursing, they should be equally stressed in nursing care of a curative nature for children in schools. The best standards of nursing technique observed in a bedside service apply to treatments given in school as well.

Nursing care is given in most cases when the accident occurs at school or on the school grounds. In order to prevent a high incidence of absence from school,

*This is the third discussion in the *Study Program* for school nurses. Reprints are available free to N.O.P.H.N. members and at 10 cents each to others.

**"Responsibilities of Medical Profession in Health Program of Public Schools." By Fred Moore, M.D. *Journal of American Medicine*, April, 1930.

infectious diseases of the skin such as scabies and impetigo are sometimes treated at school as well as at home, so as to minimize the danger to other children. Occasionally other treatments are given in school as continuation of the care given by physician or clinic, or in the home.

### ACTIVITIES ACTUALLY CARRIED ON

In studying the activities of nurses of 18 Boards of Education and 12 Departments of Health* in communities of various sizes in the United States, the most usual types of "nursing treatments" prevalent in school nursing services were found to be, according to frequency of occurrence, as follows:

Dressing of minor injuries, bruises, scratches, cuts, etc.
Treatment of scabies
Treatment of impetigo
Dressing or cleansing infections, furuncles, wounds, etc.
Treatment of pediculosis
Application of hot water bottle
Removal of foreign body from eye
Painting throat
Irrigating ear
Treating eyelid with ointment
Administering medication.

The first three types of treatments were given much more often than the others and dressings of minor injuries occurred most frequently of all.

### FIRST AID—WHOSE RESPONSIBILITY?

In all of the agencies here considered (18 Boards of Education and 12 Departments of Health) first aid is taught to teachers or pupils, or both, in only 3, or 10 per cent of them. It is as important to instruct pupil or teacher in giving this type of emergency care in school as it is to teach family members to give care to the sick at home. The nurse cannot always be in the school, and someone must be responsible for first aid in her absence. Various methods have been worked out for assigning responsibility for emergency care when the nurse is not there. In some places the principal assumes that responsibility; in others a teacher or several teachers in rotation; in places where older students have had the benefit of classes in first aid, they may be enlisted to take charge, each being made responsible for a group of classrooms.

It is a fundamental principle that all nursing care be given under medical direction or orders. In case of nursing services in school these orders should be in the form of standing orders for routine treatments, either from the medical director of the health service, where there is one, with the knowledge and approval of the organized local medical group, or, when there is no medical director, standing orders should be obtained directly from the local medical organization. In addition, of course, certain special treatments may be carried out under special order of school or private physicians.

### ASSIGNMENT FOR FURTHER STUDY

Make an analysis of all your treatments in school for one week, classifying them accordingly: Those that might be the responsibility of the parent to have treated at home or by a physician or clinic; those that must be treated at school that the nurse alone can take care of; those that must be treated at school that the teacher or student assistant can take care of.

### REFERENCES

Chayer, Mary Ella. "School Nursing." Chapter III. G. P. Putnam's Sons, N. Y.
Mitchell, Harold H. "First Aid as It Affects Nurse or Teacher Load." PUBLIC HEALTH NURSING, September, 1933.
Moore, Fred. See footnote, page 108.
White House Conference. The School Health Program. D. Appleton-Century Co., N. Y.

*Survey of Administration and Practice of Public Health Nursing in the U. S. A. Conducted under the auspices of the N.O.P.H.N. In process of publication by the Commonwealth Fund, N. Y.

# REVIEWS AND BOOK NOTES

*Edited by* DOROTHY J. CARTER

### RURAL ADULT EDUCATION

By Benson Y. Landis and John D. Willard. The Macmillan Company, New York. Price $1.75

"The purpose of this book is to interpret important programs of rural adult education in the United States and to suggest measures for their improvement."

Since 1928 the American Association for Adult Education has been conducting a national research project in adult education. This book presents the results of this study giving a complete and interesting account of all important educational programs and activities touching the lives of 53,000,000 individuals in rural America. Chief among the programs offered is that of the Agricultural Extension System reaching into the home life of millions of families and teaching scientific methods of agriculture to the farmer.

Descriptions of the various organizations, their activities and results are interestingly portrayed, showing the origin of such movements as the Grange and the Folk schools, with a detailed description of the contributions made by parent-teacher and child study associations, the extension departments of state universities and colleges, libraries, religious organizations, public schools and community groups. Special reference is made to the dynamic effect of the radio.

Interesting developments in the cultural arts are described including the little theatre activities for which Professors Arvold and Koch are responsible. The development of programs of music and its appreciation, of recreational activities and landscape improvement projects reveal the variety of activities through which adult education is continued.

The book presents a challenge and plea for an integrated system of sound theory and effective practice in a continuing educational program in rural districts. With its complete bibliography, it offers valuable source material for the student in the social sciences.

LILY CAREY JONES.

### MATERNAL MORTALITY IN NEW YORK CITY

By the New York Academy of Medicine Committee on Public Health Relations. The Commonwealth Fund, New York. Price $2.00.

"The hazards of childbirth in New York City are greater than they need be. Responsibility for reducing them rests with the medical profession."

This is the conclusion of the study of all puerperal deaths in New York City during 1930-1932. That this study was sponsored and conducted by the medical profession itself is significant.

### TESTAMENT OF YOUTH

By Vera Brittain. The Macmillan Company, New York. Price $2.50

The World War is said to have cost 8,000,000 lives, but to Vera Brittain the lives of three—her lover, her brother, and her brother's friend—meant all the world. This "testament of youth" as to what the war did to the minds and hearts of the war generation of young people, is the best war book yet written by a woman. Miss Brittain served as a V.A.D. throughout the four tragic years and her descriptions of nurses and nursing, her experiences in English hospitals, in Malta, and at the Front, will bring back vividly the memory of those hectic days to our nurses who served overseas and make the rest of us realize as never before what WAR means. The book, while sad, is not hopeless. Miss Brittain finds a new world for herself, and who shall say it is not a richer world, if the lesson of the war *stays* learned!

D. D.

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Like an international fairy tale reads the *Annual Report of the Rockefeller Foundation for 1932*. From research

on yellow fever in Africa to a health unit in Ceylon, one skims along, noting particularly the nursing education projects in Tokyo, Toronto, Lyon, and the United States, as well as a survey of nursing in India. Interesting, too, are the archeological excavations in Egypt and Persia and the numerous contributions toward the promotion of more harmonious international relations, so badly needed at the present time.

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### RECENT PUBLICATIONS

THE THIRD AMERICAN REVOLUTION. By Benson Y. Landis. New York Association Press, New York. Paper $1.00, cloth $1.75. To assist discussion groups and classes as well as individuals in understanding the New Deal.

NERVOUS AND MENTAL DISEASES FOR NURSES. By Irving J. Sands, M.D. Second edition. W. B. Saunders Company, Philadelphia. Price $1.75. Includes chapters on mental hygiene and psychoanalysis.

DIET AND PERSONALITY. By L. Jean Bogert, Ph.D. The Macmillan Company, New York. Price $2.00. A student of nutrition discusses in non-technical language the problem of fitting food to type and environment.

NATIONAL CONFERENCE OF SOCIAL WORK, DETROIT, 1933. University of Chicago Press, Chicago, Ill. Price $3.00. The *Proceedings* of the Detroit Conference including the two papers receiving the Pugsley award for the most important contribution of the year to the subject matter of social work—"Recent Changes in the Philosophy of Social Workers" by Antoinette Cannon, and "Next Steps in Job Analysis" by Neva R. Deardorff, and many others of interest and value.

THE ARCHES OF THE YEARS. By Halliday Sutherland. William Morrow & Co., New York. Price $2.75. An entertaining autobiographical account of the life and experiences of a Scotch physician.

THE SCIENTIFIC BASIS OF SOCIAL WORK. By Maurice J. Karpf. Columbia University Press, New York. $3.75. A thoughtful analysis by the Director of the Graduate School for Jewish Social Work, New York City.

GOOD EYES FOR LIFE. By Olive Grace Henderson and Hugh Grant Rowell, M.D. Popular Health Series. Appleton-Century, New York. Price $2.00.

WHAT IS EUGENICS. By Leonard Darwin. Published by the Third International Congress of Eugenics New York, 1932. A complete answer to this sometimes puzzling question.

### A BARGAIN FOR TEACHERS

*Understanding the Child—A Magazine for Teachers,* published quarterly by the Massachusetts Society for Mental Hygiene, has reduced the subscription price from one dollar to fifty cents a year. Address: 3 Joy Street, Boston, Massachusetts.

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"Are We a Nation of 12-year-olds?" David Segel, Specialist in Tests and Measurements in the U. S. Office of Education explodes this popular myth by showing that the average mental age of the men and women of this country is 17.7.—*School Life* for December, 1933.

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### REPRINTS AND PAMPHLETS

The following articles published in *The Sight-Saving Review* are available in reprint form from the National Society for the Prevention of Blindness, 450 Seventh Avenue, N. Y.

Concerning Senile Cataract. Luther C. Peter, M.D. 10c.

Diet and Eye Health. Walter F. King, M.D. 5c.

Eyes and Athletics. Free.

Eye Examinations in a Zinc Ore Industry. R. H. Seip. 5c.

Lighting for the Conservation of Vision. Percy W. Cobb, M.D. 15c.

Trachoma in the Native White Population of the U. S. C. E. Rice, M.D., and Avery A. Drake, M.D. 10c.

Vision and Other Tests for Automobile Drivers. Maxwell Halsey. 15c.

What to Do for Cross-Eyes. Walter B. Weidler, M.D. 5c.

What Can an Organization for the Blind Do in Preventing Blindness? Conrad Berens, M.D. 15c.

### OTHER PAMPHLETS

Sex Education in the Home. Helen W. Brown, M.D. American Social Hygiene Association, 450 Seventh Ave., N. Y. 10c.

Miss Gay's Adventures in First Aid. Margaret Daly Hopkins, R.N. Nation Press Printing Co., 75 Varick St., N. Y. 15c. A simple presentation in dialogue for instruction to lay groups.


A Board and Committee Members' Section was organized at the annual meeting of the New York S.O.P.H.N. in Rochester in October. The officers of the new section are: *Chairman,* Mrs. Stewart Hancock, Syracuse; *Vice-Chairman,* Mrs. J. Morton Halstead, Brooklyn; *Secretary,* Mrs. William Baker, Rochester.

The following S.O.P.H.N. officers were also elected: *President,* Willarette Sears, Rochester; *Vice-President,* Ellen Buell, Syracuse; *Secretary,* Mrs. Grace MacLaren, Tarrytown; *Treasurer,* Bertice Rees, Buffalo; *Directors,* Pearl Kamerer, Utica; Marie Swanson, Albany; Mrs. Wm. Baker, Rochester; Mrs. J. Morton Halstead, Brooklyn.

✢

Mrs. M. A. Tinley, member of the Board of the Council Bluff (Ia.) Visiting Nurse Association, has been elected State Chairman of the Board Members' Group of the Iowa State Association of Registered Nurses.

✢

During the fall of 1933 approximately $80,000,000 was raised by community chests and other coördinated social work organizations for welfare activities not covered by federal, state, and local governmental aid, according to a report sent to President Roosevelt in the form of a New Year letter by Newton D. Baker, Chairman of the 1933 Mobilization for Human Needs.

"One hundred and ninety-five Chests raised, between the first of September and the end of December, $50,299,875. The remaining one hundred and fifty-five Community Chest campaigns and the seventy cities which make their appeal in the winter and spring should increase this total to approximately $64,000,000. Reports from joint campaigns in non-Chest cities will further swell this amount to over $80,000,000.

"One-half of the Chest cities reached 86.5 per cent of their announced goals; fifty-five reached or exceeded their goals and twenty-five reported more money for welfare activities for 1934 than for 1933. Fifty per cent of the Chests in the so-called 'farm belt' raised their quotas, in contrast to 25 per cent of the Chests in other sections of the country. Of the seven new Chests reporting this fall, six went 'over the top.' "

✢

The recent death in France of Dr. Albert Calmette came at the very height of his career as a research worker in the field of bacteriology and medical science. Dr. Calmette is perhaps most widely known for his discovery of and experimental work with B.C.G. vaccine against tuberculosis—experiments that are still being watched with world-wide interest. He was also responsible for snake-bite serum by means of which thousands of lives have been saved.

✢

The annual meeting of the New Jersey Nurses' Association, the New Jersey League of Nursing Education, and the New Jersey State Organization for Public Health Nursing will be held in Jersey City on March 22, 23, and 24. The general and section meetings of the S.O.P.H.N. are scheduled for the date of March 23.

✢

Recognizing the great importance of the early discovery of tuberculosis in pregnant women, the New York City Department of Health has established a free X-ray diagnosis service for expectant mothers in the Bellevue-Yorkville district. Private physicians are invited to send those patients who cannot afford to pay for an X-ray, and a report of the findings is sent back to the physician.

✢

Ida Brossard, Supervisor of Public Health Nursing in the Missouri State

Board of Health, was elected Chairman of the Public Health Nursing Section of the Missouri State Nurses' Association at its annual meeting at Springfield in October. The day's meetings of the Public Health Nursing Section were devoted entirely to a discussion of lay participation in the field of nursing.

✣

The annual meeting of the Connecticut State Nurses' Association will be held at the Hotel Bond in Hartford February 7-9, 1934.

✣

An informative course on the eye and its pathology, treatment and hygiene will be given at New York University, New York City, under the auspices of the Prevention Department of the Division for the Blind in the New York State Department of Social Welfare. The lectures will be presented by the University staff, by leading ophthalmologists, and workers in specialized fields. The program is designed for social workers and nurses in many types of situations as well as for others in allied fields. Classes will be held at the Washington Square Center beginning February 6 and continuing to May 17.

✣

The first Leisure Time School in the United States was established last year in Racine, Wisconsin, by Miss Harriet A. Harvey, a high school teacher.

✣

The State of Washington Nurse Practice Act was amended March, 1933, requiring that each Washington registered nurse pay a renewal fee of $1 within sixty days after January 1, 1934, and each year thereafter. If not paid within the specified time a penalty is added. Nurses are requested to send renewal fee to Harry Huse, Director, License Department, Olympia, Washington. Nurses not in active nursing should secure information relative to going on the inactive list.

Headquarters office of the New York State Nurses' Association, which has been located in New York City since 1926, moved to Albany in January and is now situated in the Stratton Building, 103 Washington Street, Albany, N. Y.

✣

The Michigan Board of Registration of Nurses will hold an examination March 8-9 for graduate nurses (March 8 for trained attendants), at the Olds Hotel, Lansing. All applications with fees must be on file in the office of the Board of Registration of Nurses, 200 Hollister Building, Lansing, not later than February 21.

The Michigan Board of Registration of Nurses will hold an examination March 22-23 for graduate nurses (March 22 for trained attendants) at the Book-Cadillac Hotel, Detroit. All applications with fees must be on file in the office of the Board of Registration of Nurses, 200 Hollister Building, Lansing, not later than March 7.

✣

## RECENT APPOINTMENTS

On February 1 Miss Elizabeth S. Taylor assumed her duties as Director of the Bureau of Public Health Nursing of the Connecticut State Department of Health. Miss Taylor has done postgraduate work at Teachers College, Columbia, and has had several years' experience as staff nurse and supervisor at the East Harlem Nursing and Health Service, as well as experience in social service.

Miss Maud Tollefson, formerly director of the teaching center in St. Francis County, Missouri, has been appointed county nurse for Vernon County, Wisconsin.

Miss Margaret A. Tracy, recently of the Yale School of Nursing, has been appointed Director of the Training School for Nurses and Superintendent of Nurses at the University of California Hospital, and will also serve as Assistant Professor of Nursing Education in the University. Miss Tracy's experience includes two years with the Henry Street Visiting Nurse Service in New York City.

Miss Dorothy Rood has been made Assistant to the Extension Secretary in public health nursing on the staff of the New York State Department of Health.